

476
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Springfield State Hospital				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3701-4			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sykesville, Maryland				d. STREET ADDRESS 1011 W. 38th St.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Mary Middle Merson Last ADELSPERGER				4. DATE OF DEATH Month January Day 7 Year 1958			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 26, 1876	
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months 81 Days 81 Hours 81 Min. 81		IF UNDER 24 HRS. Months 81 Days 81 Hours 81 Min. 81			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME George Merson				14. MOTHER'S MAIDEN NAME Julia Whitehead			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. -		17. INFORMANT Address Springfield Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive cardiovascular disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. associated with circ. dist., with cerebral arteriosclerosis, with psychotic reaction.							INTERVAL BETWEEN ONSET AND DEATH 2 days Years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 8, 1957 , to January 7, 1958 , that I last saw the deceased alive on January 7, 1958 , and that death occurred at 1:50 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Walther H. Sonnenfeldt M.D.				ADDRESS (Street, city or town, state) Springfield State Hospital		DATE SIGNED 1/7/58	
PHYSICIAN'S NAME (Type) Walther H. Sonnenfeldt, M.D.				Sykesville, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF JAN 10/58		22c. NAME OF CEMETERY OR CREMATORY MT. OLIVET		22d. LOCATION (City, town, or county) (State) FREDERICK RD. MD	
23. FUNERAL DIRECTOR'S SIGNATURE Austin E. Donovan				ADDRESS 3818 Roland Ave.		24a. REC'D BY REGISTRAR DATE JAN 10 '58	
				24b. REGISTRAR'S SIGNATURE Overman			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JAN 10 1968

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, MD	
CERTIFICATE OF DEATH	
1. NAME OF DECEASED JAMES EARL RAY	
2. SEX Male	
3. AGE 35	
4. DATE OF DEATH April 4, 1968	
5. PLACE OF DEATH Room 306, Airport Hotel, Memphis, Tennessee	
6. CAUSE OF DEATH Shot - self-inflicted	
7. MANNER OF DEATH Suicide	
8. SIGNATURE OF DECEASED (None)	
9. SIGNATURE OF WITNESSES (None)	
10. SIGNATURE OF PHYSICIAN (None)	
11. SIGNATURE OF CORONER (None)	
12. SIGNATURE OF DEATH CERTIFICATE (None)	
13. SIGNATURE OF DEATH CERTIFICATE (None)	
14. SIGNATURE OF DEATH CERTIFICATE (None)	
15. SIGNATURE OF DEATH CERTIFICATE (None)	
16. SIGNATURE OF DEATH CERTIFICATE (None)	
17. SIGNATURE OF DEATH CERTIFICATE (None)	
18. SIGNATURE OF DEATH CERTIFICATE (None)	
19. SIGNATURE OF DEATH CERTIFICATE (None)	
20. SIGNATURE OF DEATH CERTIFICATE (None)	

477
CERTIFICATE OF DEATH

Reg. Dist. No.

00470

1. PLACE OF DEATH o. COUNTY <u>CARROLL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) p. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UNION BRIDGE</u>				c. LENGTH OF STAY IN 1b <u>YEARS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MAIN ST</u>				d. STREET ADDRESS <u>1 MAIN ST</u>			
3. NAME OF DECEASED (Type or print) <u>AGNES ELIZABETH ANGELL</u>				4. DATE OF DEATH Month <u>JANUARY</u> Day <u>1</u> Year <u>1958</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>AUG 29-1880</u>	
9. AGE (In years last birthday) <u>77</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEKEEPER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>JOHN W. WARNER</u>		14. MOTHER'S MAIDEN NAME <u>JULIA STRAWSBURG</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>E. ANGELL UNION BRIDGE, MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocarditis</u> <u>4222</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Thrombosis</u> DUE TO (c) <u>Sum of both</u>							INTERVAL BETWEEN ONSET AND DEATH <u>DMR</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>491X</u> <u>Isotonic Metabolic Acidosis</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Jan 1, 1958</u> to <u>Dec 1, 1958</u> that I last saw the deceased alive on <u>Jan 1, 1958</u> , and that death occurred at <u>10:10 M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. H. Messle</u> M.D.				ADDRESS (Street, city or town, state) <u>Union Bridge, MD</u>			
DATE SIGNED <u>Jan 31</u>							
PHYSICIAN'S NAME (Type) <u>J. H. MESSLE</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1/4/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MT. VIEW CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>UNION BRIDGE MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>D. D. Hutchins</u>				ADDRESS <u>Union Bridge, MD</u>		24a. REC'D BY REGISTRAR DATE <u>6</u> 1958	
24b. REGISTRAR'S SIGNATURE <u>D. H. Hedrick</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
JAMES EARL RAY		35		M		W		1928		MEMPHIS		TENNESSEE		UNITED STATES		UNITED STATES	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH	
JAN 6 1968		MEMPHIS		MEMPHIS		TENNESSEE		UNITED STATES		JAN 6 1968		MEMPHIS		MEMPHIS		TENNESSEE	
CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION		RELIGION		MARRIAGE		CHILDREN		SIBLINGS		PARENTS	
SHOOTING		HOMICIDE		ATTORNEY		HIGH SCHOOL		METHODIST		MARRIED		2		2		2	
DETAILS OF DEATH		DETAILS OF DEATH		DETAILS OF DEATH		DETAILS OF DEATH		DETAILS OF DEATH		DETAILS OF DEATH		DETAILS OF DEATH		DETAILS OF DEATH		DETAILS OF DEATH	
FINGERPRINTS		FINGERPRINTS		FINGERPRINTS		FINGERPRINTS		FINGERPRINTS		FINGERPRINTS		FINGERPRINTS		FINGERPRINTS		FINGERPRINTS	
SIGNATURE OF DECEASED		SIGNATURE OF DECEASED		SIGNATURE OF DECEASED		SIGNATURE OF DECEASED		SIGNATURE OF DECEASED		SIGNATURE OF DECEASED		SIGNATURE OF DECEASED		SIGNATURE OF DECEASED		SIGNATURE OF DECEASED	
SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS	
SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN	
SIGNATURE OF CORONER		SIGNATURE OF CORONER		SIGNATURE OF CORONER		SIGNATURE OF CORONER		SIGNATURE OF CORONER		SIGNATURE OF CORONER		SIGNATURE OF CORONER		SIGNATURE OF CORONER		SIGNATURE OF CORONER	
SIGNATURE OF JUDGE		SIGNATURE OF JUDGE		SIGNATURE OF JUDGE		SIGNATURE OF JUDGE		SIGNATURE OF JUDGE		SIGNATURE OF JUDGE		SIGNATURE OF JUDGE		SIGNATURE OF JUDGE		SIGNATURE OF JUDGE	

BUREAU V. S.

JAN 6 1968

RECEIVED

478

CERTIFICATE OF DEATH

Reg. Dist. No.

00471

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Westminster</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Westminster RD # 2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Littletown Road</u>				e. STREET ADDRESS <u>Littletown Road</u>			
3. NAME OF DECEASED (Type or print) <u>CHARLES HERBERT BANGE</u>				4. DATE OF DEATH <u>JAN 27 1958</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 19 1881</u>	9. AGE (In years last birthday) <u>76</u> yrs.	10. IF UNDER 1 YEAR		11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>New Windsor Md. U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles McHenry Bange</u>				14. MOTHER'S MAIDEN NAME <u>Emma Virginia Bart</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-14-0090</u>		17. INFORMANT <u>Mr. C. H. Bange Westminster RD # 2 Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1 CEREBRAL HEMORRHAGE</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>A.S.C.V. DISEASE</u> DUE TO (c) <u>Year</u>						INTERVAL BETWEEN ONSET AND DEATH <u>30 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug 19 1956</u> , to <u>JAN 27 1958</u> , that I last saw the deceased alive on <u>JAN 26 1958</u> , and that death occurred at <u>3:45 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>James J Marsh</u>				ADDRESS (Street, city or town, state) <u>M.D. 105 E MAIN ST</u>		DATE SIGNED <u>JAN 27/58</u>	
PHYSICIAN'S NAME (Type) <u>JAMES T MARSH</u>				LOCATION (City, town, or county) (State) <u>WESTMINSTER MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/29/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>How Chapel Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Rural, Westminster Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Myers, Jr.</u>				ADDRESS <u>Westminster, Md.</u>		24a. RECEIVED BY REGISTRAR <u>Jan 28 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>C. L. Seach</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 48 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

REG. CHG. NO.



COUNTY OF _____ CITY OF _____		DEPARTMENT OF HEALTH BALTIMORE, MARYLAND	
NAME OF DECEASED _____ SEX _____ AGE _____ DATE OF BIRTH _____ PLACE OF BIRTH _____		OCCUPATION _____ MARITAL STATUS _____ PLACE OF DEATH _____	
CAUSE OF DEATH _____ ICD-9 CODE _____ MEDICAL HISTORY _____ PRE-EXISTING DISEASES _____		TIME OF DEATH _____ PLACE OF DEATH _____ SIGNATURE OF PHYSICIAN _____ DATE _____	
SIGNATURE OF REGISTRAR _____ DATE _____		SIGNATURE OF CLERK _____ DATE _____	

BUREAU V. 1

JAN 28 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00472

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 10 mos. 18 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital			d. STREET ADDRESS -		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Minnie Amanda Lee BEAVER			4. DATE OF DEATH Month Day Year January 14, 1958		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 5, 1886		9. AGE (In years last birthday) 71 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Levi Lee			14. MOTHER'S MAIDEN NAME Annie Haines		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-14-1936		17. INFORMANT Address Springfield Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolism DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with dist. of metabolism, growth or nutrition, with senile brain disease with psychotic reaction					INTERVAL BETWEEN ONSET AND DEATH Hours.
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE James T. Marsh		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 1/15/58	
EXAMINER'S NAME (Type) James T. Marsh, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 1-18-58		22c. NAME OF CEMETERY Sams Creek Brethren	
22d. LOCATION (City, town, or county) Carroll Co., Md.		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz, Winfield, Md.			24a. REC'D BY REGISTRAR DATE JAN 17 '58		
24b. REGISTRAR'S SIGNATURE [Signature]					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED: [illegible]
AGE: [illegible]
SEX: [illegible]
DATE OF BIRTH: [illegible]
PLACE OF BIRTH: [illegible]
OCCUPATION: [illegible]
EDUCATION: [illegible]
MARRIAGE: [illegible]
RELIGION: [illegible]
RACE: [illegible]
COLOR: [illegible]
DATE OF DEATH: [illegible]
PLACE OF DEATH: [illegible]
CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]
SIGNATURE OF EXAMINER: [illegible]
DATE: [illegible]

BUREAU V. S.

JAN 17 1958

RECEIVED

480

CERTIFICATE OF DEATH

00473

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hampstead</u>	c. LENGTH OF STAY IN 1b <u>40 yrs</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hampstead</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>✓</u>		d. STREET ADDRESS <u>1</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>JENNIE - A - BIXLER</u>		4. DATE OF DEATH <u>Jan 3 1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 26-1877</u>
9. AGE (In years last birthday) <u>80</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nurse</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Michael Builhart</u>		14. MOTHER'S MAIDEN NAME <u>Maudilla Hoover</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Miss Emmet Benson-Reisterstown Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Coronary Arterio-Sclerosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive C.V. diseases</u> DUE TO (c) <u>12 yrs.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>July 1955</u> to <u>January 3, 1958</u> , that I last saw the deceased alive on <u>January 2, 1958</u> , and that death occurred at <u>7:30 a. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>M.C. Porterfield</u>		DATE SIGNED <u>1-3-58</u>	
PHYSICIAN'S NAME (Type) <u>M.C. Porterfield, M.D.</u>		<u>Hampstead, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1-6-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Greenmount</u>	22d. LOCATION (City, town, or county) (State) <u>Carroll Co Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edw E. Tipton</u>		24a. REC'D BY REGISTRAR <u>Jan 7 1958</u>	
ADDRESS <u>Hampstead Md</u>		24b. REGISTRAR'S SIGNATURE <u>Outreach</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>JOHN J. SMITH</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. DATE OF DEATH <i>Jan 10 1958</i>		5. TIME OF DEATH <i>10:00 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Myocardial Infarction</i>		8. MANNER OF DEATH <i>Natural</i>		9. MEDICAL HISTORY <i>None</i>	
10. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Smith</i>		11. SIGNATURE OF DECEASED <i>John J. Smith</i>		12. SIGNATURE OF WITNESS <i>John J. Smith</i>	
13. SIGNATURE OF DECEASED <i>John J. Smith</i>		14. SIGNATURE OF WITNESS <i>John J. Smith</i>		15. SIGNATURE OF WITNESS <i>John J. Smith</i>	
16. SIGNATURE OF WITNESS <i>John J. Smith</i>		17. SIGNATURE OF WITNESS <i>John J. Smith</i>		18. SIGNATURE OF WITNESS <i>John J. Smith</i>	
19. SIGNATURE OF WITNESS <i>John J. Smith</i>		20. SIGNATURE OF WITNESS <i>John J. Smith</i>		21. SIGNATURE OF WITNESS <i>John J. Smith</i>	
22. SIGNATURE OF WITNESS <i>John J. Smith</i>		23. SIGNATURE OF WITNESS <i>John J. Smith</i>		24. SIGNATURE OF WITNESS <i>John J. Smith</i>	
25. SIGNATURE OF WITNESS <i>John J. Smith</i>		26. SIGNATURE OF WITNESS <i>John J. Smith</i>		27. SIGNATURE OF WITNESS <i>John J. Smith</i>	
28. SIGNATURE OF WITNESS <i>John J. Smith</i>		29. SIGNATURE OF WITNESS <i>John J. Smith</i>		30. SIGNATURE OF WITNESS <i>John J. Smith</i>	
31. SIGNATURE OF WITNESS <i>John J. Smith</i>		32. SIGNATURE OF WITNESS <i>John J. Smith</i>		33. SIGNATURE OF WITNESS <i>John J. Smith</i>	
34. SIGNATURE OF WITNESS <i>John J. Smith</i>		35. SIGNATURE OF WITNESS <i>John J. Smith</i>		36. SIGNATURE OF WITNESS <i>John J. Smith</i>	
37. SIGNATURE OF WITNESS <i>John J. Smith</i>		38. SIGNATURE OF WITNESS <i>John J. Smith</i>		39. SIGNATURE OF WITNESS <i>John J. Smith</i>	
40. SIGNATURE OF WITNESS <i>John J. Smith</i>		41. SIGNATURE OF WITNESS <i>John J. Smith</i>		42. SIGNATURE OF WITNESS <i>John J. Smith</i>	
43. SIGNATURE OF WITNESS <i>John J. Smith</i>		44. SIGNATURE OF WITNESS <i>John J. Smith</i>		45. SIGNATURE OF WITNESS <i>John J. Smith</i>	
46. SIGNATURE OF WITNESS <i>John J. Smith</i>		47. SIGNATURE OF WITNESS <i>John J. Smith</i>		48. SIGNATURE OF WITNESS <i>John J. Smith</i>	
49. SIGNATURE OF WITNESS <i>John J. Smith</i>		50. SIGNATURE OF WITNESS <i>John J. Smith</i>		51. SIGNATURE OF WITNESS <i>John J. Smith</i>	
52. SIGNATURE OF WITNESS <i>John J. Smith</i>		53. SIGNATURE OF WITNESS <i>John J. Smith</i>		54. SIGNATURE OF WITNESS <i>John J. Smith</i>	
55. SIGNATURE OF WITNESS <i>John J. Smith</i>		56. SIGNATURE OF WITNESS <i>John J. Smith</i>		57. SIGNATURE OF WITNESS <i>John J. Smith</i>	
58. SIGNATURE OF WITNESS <i>John J. Smith</i>		59. SIGNATURE OF WITNESS <i>John J. Smith</i>		60. SIGNATURE OF WITNESS <i>John J. Smith</i>	
61. SIGNATURE OF WITNESS <i>John J. Smith</i>		62. SIGNATURE OF WITNESS <i>John J. Smith</i>		63. SIGNATURE OF WITNESS <i>John J. Smith</i>	
64. SIGNATURE OF WITNESS <i>John J. Smith</i>		65. SIGNATURE OF WITNESS <i>John J. Smith</i>		66. SIGNATURE OF WITNESS <i>John J. Smith</i>	
67. SIGNATURE OF WITNESS <i>John J. Smith</i>		68. SIGNATURE OF WITNESS <i>John J. Smith</i>		69. SIGNATURE OF WITNESS <i>John J. Smith</i>	
70. SIGNATURE OF WITNESS <i>John J. Smith</i>		71. SIGNATURE OF WITNESS <i>John J. Smith</i>		72. SIGNATURE OF WITNESS <i>John J. Smith</i>	
73. SIGNATURE OF WITNESS <i>John J. Smith</i>		74. SIGNATURE OF WITNESS <i>John J. Smith</i>		75. SIGNATURE OF WITNESS <i>John J. Smith</i>	
76. SIGNATURE OF WITNESS <i>John J. Smith</i>		77. SIGNATURE OF WITNESS <i>John J. Smith</i>		78. SIGNATURE OF WITNESS <i>John J. Smith</i>	
79. SIGNATURE OF WITNESS <i>John J. Smith</i>		80. SIGNATURE OF WITNESS <i>John J. Smith</i>		81. SIGNATURE OF WITNESS <i>John J. Smith</i>	
82. SIGNATURE OF WITNESS <i>John J. Smith</i>		83. SIGNATURE OF WITNESS <i>John J. Smith</i>		84. SIGNATURE OF WITNESS <i>John J. Smith</i>	
85. SIGNATURE OF WITNESS <i>John J. Smith</i>		86. SIGNATURE OF WITNESS <i>John J. Smith</i>		87. SIGNATURE OF WITNESS <i>John J. Smith</i>	
88. SIGNATURE OF WITNESS <i>John J. Smith</i>		89. SIGNATURE OF WITNESS <i>John J. Smith</i>		90. SIGNATURE OF WITNESS <i>John J. Smith</i>	
91. SIGNATURE OF WITNESS <i>John J. Smith</i>		92. SIGNATURE OF WITNESS <i>John J. Smith</i>		93. SIGNATURE OF WITNESS <i>John J. Smith</i>	
94. SIGNATURE OF WITNESS <i>John J. Smith</i>		95. SIGNATURE OF WITNESS <i>John J. Smith</i>		96. SIGNATURE OF WITNESS <i>John J. Smith</i>	
97. SIGNATURE OF WITNESS <i>John J. Smith</i>		98. SIGNATURE OF WITNESS <i>John J. Smith</i>		99. SIGNATURE OF WITNESS <i>John J. Smith</i>	
100. SIGNATURE OF WITNESS <i>John J. Smith</i>		101. SIGNATURE OF WITNESS <i>John J. Smith</i>		102. SIGNATURE OF WITNESS <i>John J. Smith</i>	

BUREAU V. S.

JAN 7 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00474

CERTIFICATE OF DEATH

Item 16, Film G224, 1/21/58

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL NEW WINDSOR</u>		c. LENGTH OF STAY IN 1b <u>YEARS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL NEW WINDSOR</u> x	
		d. STREET ADDRESS <u>1</u>	
		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>WILBUR RULLETTE BLACKSTEN</u>		4. DATE OF DEATH Month Day Year <u>11 13 1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/15/1900</u>
9. AGE (In years last birthday) <u>57</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>TENANT</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>HOWARD BLACKSTEN</u>		14. MOTHER'S MAIDEN NAME <u>ANNIE SMITH</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>214-36-9687</u>	
17. INFORMANT <u>DAISY BLACKSTEN</u>		Address <u>RURAL NEW WINDSOR MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis c-v disease</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1950</u> to <u>1/13</u> , <u>1958</u> , that I last saw the deceased alive on <u>1/13</u> , <u>1958</u> , and that death occurred at <u>PP</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>James J. Marsh</u> M.D. <u>1/14/58</u>			
ACTUAL SIGNATURE		PHYSICIAN'S NAME (Type) <u>JAMES T. MARSH</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1/16/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>WINTERS</u>		22d. LOCATION (City, town, or county) (State) <u>CARROLL CO MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>DD Hartzler</u>		ADDRESS <u>Lower Union Bridge Md</u>	
24a. REC'D BY REGISTRAR <u>JAN 1 7 58</u>		24b. REGISTRAR'S SIGNATURE <u>Overman</u>	

RECEIVED

482
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>CARROLL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL NEW WINDSOR</u>		c. LENGTH OF STAY IN 1b <u>40 YRS.</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL NEW WINDSOR</u>		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) <u>MARGIE</u> First <u>VIOLA</u> Middle <u>BOWERS</u> Last <u>OK</u>		4. DATE OF DEATH <u>JAN.</u> Month <u>9</u> Day <u>1958</u> Year	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 5, 1897</u>
9. AGE (In years last birthday) <u>60</u> yrs.		IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN W. BLACK</u>		14. MOTHER'S MAIDEN NAME <u>LEE ANNA FOUTZ</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>23-18-8266</u>	
17. INFORMANT <u>MRS STUART ZENDEGRAFF WESTMINSTER</u>		Address <u>PENNA. AVE.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO <u>Hypertensive chronic</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Myocarditis & Valvular</u> DUE TO <u>Stenosis</u> (c) <u>Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>several</u> <u>4 yrs</u> <u>5 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 9, 1956</u> to <u>Jan 9, 1958</u> , that I last saw the deceased alive on <u>Dec 20, 1957</u> , and that death occurred at <u>5:15 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. Gordon Speicher</u>		ADDRESS (Street, city or town, State) <u>Westminster, Md</u>	
PHYSICIAN'S NAME (Type) <u>W. Gordon Speicher</u>		DATE SIGNED <u>1/4/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1-12-1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ST. JAMES CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>DENNING'S</u> <u>MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>David W. Burkard</u>		ADDRESS <u>Westminster, Md.</u>	
24a. REC'D BY REGISTRAR <u>DATE JAN 14 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. Gordon Speicher</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00476

483

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY _____			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Sykesville</u>				c. LENGTH OF STAY IN TB <u>since 2/29/56</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hospital</u>				d. STREET ADDRESS <u>3904 Northern Parkway</u>			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Mathews</u> Last <u>BRAY</u>				4. DATE OF DEATH Month <u>January</u> Day <u>7</u> Year <u>19 58</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 11, 1881</u>	
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Pharmacist</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
13. FATHER'S NAME <u>Reuben Bray</u>				14. MOTHER'S MAIDEN NAME <u>Rachel Emily Dorsett</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>220-07-5804</u>		17. INFORMANT <u>Records of Springfield State Hospital</u>		Address <u>Sykesville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic coronary thrombosis</u> DUE TO (c) <u>Arteriosclerotic cardiovascular disease</u>							INTERVAL BETWEEN ONSET AND DEATH <u>acute</u> <u>acute</u> <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CBS assoc. with circulatory disturbance, with cerebral arteriosclerosis, with psychotic reaction.</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____		20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____					
21. I certify that I attended the deceased from <u>Apr. 27</u> , 19 <u>56</u> , to <u>Jan. 7</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>January 6</u> , 19 <u>58</u> , and that death occurred at <u>6:30 A</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Walther H. Sonnenfeldt</u>				ADDRESS (Street, city or town, state) <u>Springfield State Hospital</u>		DATE SIGNED <u>1/7/58</u>	
PHYSICIAN'S NAME (Type) <u>Walther Sonnenfeldt, M.D.</u>				<u>Sykesville, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>1-10-58</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cem</u>		22d. LOCATION (City, town, or county) <u>Bald</u> (State) <u>Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>				ADDRESS <u>305 Harford</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 13 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. H. Beach</u>			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

with cerebral arteriosclerosis, x

BUREAU V. S.

JAN 13 1938

RECEIVED

28

6:30 A Jan. 7

Apr. 27

28

January 6

Walter S. Lawrence

CERTIFICATE OF DEATH

Reg. Dist. No. 00477

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY City Baltimore ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 9 yrs. 9 mos 22 dys.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				e. STREET ADDRESS 3115 Hilltop Avenue			
3. NAME OF DECEASED (Type or print) First Florence Middle Celeste Last BROWN				4. DATE OF DEATH Month January Day 29 Year 1958			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 20, 1875	
9. AGE (In years last birthday) 82 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Julius Bartholomeu				14. MOTHER'S MAIDEN NAME Sarah King			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT Spr. St. Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction with perforation DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) of the left ventricular wall. DUE TO (c) Generalized arteriosclerosis							INTERVAL BETWEEN ONSET AND DEATH Minutes
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. syndrome, asso. with dist. of metabolism, growth or nutrition with senile brain disease, without qualifying							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10-20-54 , 19 54 , to 1-29 , 19 58 , that I last saw the deceased alive on 1-29 , 19 58 , and that death occurred at 11:15 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Edmund Lusthaus				ADDRESS (Street, city or town, state) Springfield State Hospital		DATE SIGNED 1-29-58	
PHYSICIAN'S NAME (Type) Edmund Lusthaus M.D.				Sykesville, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/1/58		22c. NAME OF CEMETERY OR CREMATORY Arnold Ridge		22d. LOCATION (City, town, or county) (State) Balts. Co	
23. FUNERAL DIRECTOR'S SIGNATURE James M. Smith & Son				ADDRESS 28		24a. REC'D BY REGISTRAR DATE FEB 3 '58	
				24b. REGISTRAR'S SIGNATURE Alfred Smith			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. HARRIS		Male		35		April 20, 1892		Baltimore, Md.	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH	
1012 N. E. Street		Carpenter		Myocardial Infarction		Natural		Home	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		MANNER OF DEATH		PLACE OF DEATH	
April 25, 1938		10:15 AM		Home		Natural		Home	
SIGNATURE OF PHYSICIAN		SIGNATURE OF WITNESSES		SIGNATURE OF DECEASED		SIGNATURE OF DECEASED		SIGNATURE OF DECEASED	
J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		MANNER OF DEATH		PLACE OF DEATH	
April 25, 1938		10:15 AM		Home		Natural		Home	

RECEIVED
BUREAU V. 8
EB 8 1958

485

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural--Sykesville		c. LENGTH OF STAY IN IB Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARGARET Middle ELLEN Last BUSHEY		4. DATE OF DEATH Month Jan Day 10 Year 1958	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-8-1939
9. AGE (In years last birthday) 18 yrs.		10. IF UNDER 1 YEAR Months 18 Days 10 Hours 10 Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U.S.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Frank L. Bushey		14. MOTHER'S MAIDEN NAME Mary Virginia Grimm	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Frank L. Bushey,		Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA BRONCHIAL, OTITIS MEDIA, 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CARDIAC FAILURE, I DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 5 Jan 58 10 Jan 58			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7 Jan , 19 58 , to 10 Jan , 19 58 , that I last saw the deceased alive on 10 Jan , 19 58 , and that death occurred at 8:25 P. M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Howard E. Hall		ADDRESS (Street, city or town, state) Asheville, N.C. DATE SIGNED 10 Jan 58	
PHYSICIAN'S NAME (Type) HOWARD E. HALL			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 1-13-1958	22c. NAME OF CEMETERY OR CREMATORIUM Westminster	22d. LOCATION (City, town, or county) (State) Westminster, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz,		ADDRESS Winfield, Maryland	
24a. REC'D BY REGISTRAR DATE JAN 13 '58		24b. REGISTRAR'S SIGNATURE W. Leach	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JAN 13 1959

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00479

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL NEW WINDSOR</u>	c. LENGTH OF STAY IN 1b <u>MONTHS</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X RURAL NEW WINDSOR</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>1</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>PATRICIA ANN BUTLER</u>		4. DATE OF DEATH <u>JAN 1 1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>COL</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG 16 - 1957</u>
9. AGE (In years last birthday) <u>4</u> yrs.		IF UNDER 1 YEAR <u>4</u> Months	IF UNDER 24 HRS. <u>4</u> Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>	11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>CHARLES WM BUTLER</u>	
14. MOTHER'S MAIDEN NAME <u>LOUISE BUTLER</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>	
16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>LOUISE BUTLER NEW WINDSOR MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE BRONCHOPNEUMONIA</u> DUE TO <u>491X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>491X</u> DUE TO (c) <u>491X</u>			INTERVAL BETWEEN ONSET AND DEATH <u>HOURS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>James J. Marsh</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JAMES T. MARSH</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1/13/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>WESTERN CHAPEL</u>
22d. LOCATION (City, town, or county) <u>CARROLL CO</u>		(State) <u>MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>DD Hartzler & Sons</u>		ADDRESS <u>New Windsor, Md</u>	
24a. REC'D BY REGISTRAR <u>6</u>		24b. REGISTRAR'S SIGNATURE <u>A. H. Hedrick</u>	

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH - BOSTON 19
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED

BUREAU V. S.

JAN 6 1938

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Henryton				c. LENGTH OF STAY IN 1b 1,970 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Henryton State Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3V01-4			
3. NAME OF DECEASED (Type or print) First Lee Middle Cade Last Cade				4. DATE OF DEATH Month January Day 30 Year 19 58			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-4-1902	
9. AGE (In years last birthday) 55 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		11. BIRTHPLACE (State or foreign country) Lumberton, N. C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Peter Cade				14. MOTHER'S MAIDEN NAME Sally Johnson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 718-10-7081		17. INFORMANT Lee Cade - Patient Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Far advanced bilateral pulmonary Tbc., Aneurysm DUE TO of the aorta. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Late Syphilis DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 5 1/2 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 022x							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from September 8, 19 52 , to January 30, 19 58 , that I last saw the deceased alive on January 30, 19 58 , and that death occurred at 11:55AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Henryton, Maryland DATE SIGNED 1-30-58							
ACTUAL SIGNATURE Edgars M. Maculans M.D. M.D.				HENRYTON, MARYLAND			
PHYSICIAN'S NAME (Type) Edgars M. Maculans, M. D., Supt.				HENRYTON STATE HOSPITAL			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 2-4-58		22c. NAME OF CEMETERY OR CREMATORY SOUTH CAROLINA		22d. LOCATION (City, town, or county) (State) SOUTH CAROLINA	
23. FUNERAL DIRECTOR'S SIGNATURE WILLIAM A. JACKSON INC. ADDRESS 916 PENNA. AVE.				24a. REC'D BY REGISTRAR TEB 3 '58		24b. REGISTRAR'S SIGNATURE W. Jackson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. PLACE OF DEATH		2. DATE OF DEATH	
3. TIME OF DEATH		4. PLACE OF DEATH	
5. NAME OF DECEASED		6. SEX	
7. AGE		8. RACE	
9. OCCUPATION		10. MARITAL STATUS	
11. CAUSE OF DEATH		12. MANNER OF DEATH	
13. SIGNATURE OF PHYSICIAN		14. SIGNATURE OF REGISTRAR	
15. SIGNATURE OF WITNESSES		16. SIGNATURE OF DECEASED	
17. SIGNATURE OF FUNERAL HOME		18. SIGNATURE OF BURIAL PLACE	
19. SIGNATURE OF CORONER		20. SIGNATURE OF JURY	
21. SIGNATURE OF JUDGE		22. SIGNATURE OF CLERK	
23. SIGNATURE OF SHERIFF		24. SIGNATURE OF DEPUTY SHERIFF	
25. SIGNATURE OF CONSTABLE		26. SIGNATURE OF DEPUTY CONSTABLE	
27. SIGNATURE OF TOWNSHIP CLERK		28. SIGNATURE OF COUNTY CLERK	
29. SIGNATURE OF STATE CLERK		30. SIGNATURE OF FEDERAL CLERK	

BUREAU V. 3

1958 FEB 3

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 00481

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 2 y 11 m 25 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3401-4	
d. STREET ADDRESS 1220 E. Cold Spring Lane #12		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Joseph Middle CATANZARO Last CATANZARO		4. DATE OF DEATH Month January Day 4 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 6, 1874
9. AGE (In years last birthday) 83 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stone Mason		10b. KIND OF BUSINESS OR INDUSTRY Self Employed	
11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? Italy	
13. FATHER'S NAME Sylvester Catanzaro		14. MOTHER'S MAIDEN NAME Angelina -	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. -	
17. INFORMANT Springfield Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH Years Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with dist. of metabolism, growth or nutrition with senile brain disease, with psychotic reaction.			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January 9, 1955 to January 4, 1958 , that I last saw the deceased alive on January 3, 1958 , and that death occurred at 12:50 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 1/4/58 ACTUAL SIGNATURE Edmund Lusthaus M.D. PHYSICIAN'S NAME (Type) Edmund Lusthaus, M.D. Sykesville, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/8/58	
22c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tackner & Sons ADDRESS North Pa Aves.		24a. REC'D BY REGISTRAR DATE JAN 6 '58	
24b. REGISTRAR'S SIGNATURE Wm. J. Tackner			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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RECEIVED

489

CERTIFICATE OF DEATH

Reg. Dist. No. 00482

1. PLACE OF DEATH o. COUNTY CARROLL MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SYKESVILLE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE 3V01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) SPRINGFIELD STATE HOSPITAL		d. STREET ADDRESS 504 GILMORE ST	
3. NAME OF DECEASED (Type or print) First Middle Last George Raymond CHANEY		4. DATE OF DEATH Month Day Year Jan 22 1958	
5. SEX male	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1883
9. AGE (In years lost birthday) 75 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY none	11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME CHARLES B. CHANEY	
14. MOTHER'S MAIDEN NAME MARY E. BOYCE		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO	
16. SOCIAL SECURITY NO. —		17. INFORMANT Address Records of SPRINGFIELD HOSPITAL	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL HAEIMORRHAGE DUE TO GENERALIZED ARTERIOSCLEROSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) MORE THAN 10Y. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 DAY	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) MENTAL DEFICIENCY, SEVERE IDIOPATHIC		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from MARCH, 1956 to Jan 20, 1958 that I last saw the deceased alive on Jan 20, 1958 , and that death occurred at 4:45 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Walter Knopp		DATE SIGNED 1-22-58	
PHYSICIAN'S NAME (Type) WALTER KNOPP		ADDRESS (Street, city or town, state) SPRINGFIELD STATE HOSP. Sykesville MARYLAND	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Jan 25, 1958	22c. NAME OF CEMETERY OR CREMATORY Landon Park	22d. LOCATION (City, town, or county) (State) Baltimore Maryland
23. FUNERAL DIRECTOR'S SIGNATURE DeWitt Landon Park, Md		24a. REC'D BY REGISTRAR DATE JAN 27 '58	
24b. REGISTRAR'S SIGNATURE Albrecht			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. HARRIS		Male		45		Jan 15, 1890		Baltimore, Md.	
MARRIAGE		SINGLE		MARRIED		DIVORCED		WIDOWED	
DATE OF MARRIAGE		DATE OF DIVORCE		DATE OF WIDOWED		DATE OF DEATH		PLACE OF DEATH	
Jan 10, 1910		None		None		Jan 27, 1935		Baltimore, Md.	
CAUSE OF DEATH		DISEASE		INJURY		POISON		OTHER	
Heart Disease		None		None		None		None	
NATURE OF DISEASE		DISEASE		INJURY		POISON		OTHER	
Coronary Artery Disease		None		None		None		None	
DATE OF DEATH		PLACE OF DEATH		DATE OF DEATH		PLACE OF DEATH		DATE OF DEATH	
Jan 27, 1935		Baltimore, Md.		Jan 27, 1935		Baltimore, Md.		Jan 27, 1935	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED	
None		None		None		None		None	
DATE OF DEATH		PLACE OF DEATH		DATE OF DEATH		PLACE OF DEATH		DATE OF DEATH	
Jan 27, 1935		Baltimore, Md.		Jan 27, 1935		Baltimore, Md.		Jan 27, 1935	

BUREAU V. S.

JAN 27 1935

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

00483

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hampstead Rural</u>		c. LENGTH OF STAY IN 1b <u>Life</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Black Rock Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Elizabeth</u> Last <u>Cole</u>		4. DATE OF DEATH Month <u>January</u> Day <u>4</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 26, 1908</u>
9. AGE (In years last birthday) <u>49</u> yrs.		10. IF UNDER 1 YEAR Months <u>4</u> Days <u>9</u> Hours <u>19</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert Merryman</u>		14. MOTHER'S MAIDEN NAME <u>Rosella Grmacost</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>218-32-5617</u>	
17. INFORMANT <u>John Thomas Cole</u>		Address <u>Hampstead Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO <u>422.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebrovascular disease</u> DUE TO <u>260x</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Rheumatic fever</u>		INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>—</u> <u>—</u> 19 <u>—</u> p. m. <u>—</u> <u>—</u> <u>—</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>October 23, 1957</u> to <u>Jan 4, 1958</u> , that I last saw the deceased alive on <u>Jan 4, 1958</u> , and that death occurred at <u>3:10 P.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Joseph E. Bush</u>		DATE SIGNED <u>1/4/58</u>	
PHYSICIAN'S NAME (Type) <u>Joseph E. Bush MD</u>		ADDRESS (Street, city or town, state) <u>Hampstead, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan 7-1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Grace</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edw E. Nixton</u>		ADDRESS <u>Hampstead Md</u>	
24a. REG'D BY REGISTRAR <u>Jan 7 58</u>		24b. REGISTRAR'S SIGNATURE <u>W. E. Nixton</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>		4. RACE <i>White</i>	
5. PLACE OF BIRTH <i>Baltimore, Md.</i>		6. DATE OF BIRTH <i>Jan 1, 1910</i>		7. TIME OF DEATH <i>10:00 AM</i>		8. CAUSE OF DEATH <i>Heart Disease</i>	
9. PLACE OF DEATH <i>Home</i>		10. DATE OF DEATH <i>Jan 1, 1958</i>		11. TIME OF DEATH <i>10:00 AM</i>		12. CAUSE OF DEATH <i>Heart Disease</i>	
13. PLACE OF DEATH <i>Home</i>		14. DATE OF DEATH <i>Jan 1, 1958</i>		15. TIME OF DEATH <i>10:00 AM</i>		16. CAUSE OF DEATH <i>Heart Disease</i>	
17. PLACE OF DEATH <i>Home</i>		18. DATE OF DEATH <i>Jan 1, 1958</i>		19. TIME OF DEATH <i>10:00 AM</i>		20. CAUSE OF DEATH <i>Heart Disease</i>	
21. PLACE OF DEATH <i>Home</i>		22. DATE OF DEATH <i>Jan 1, 1958</i>		23. TIME OF DEATH <i>10:00 AM</i>		24. CAUSE OF DEATH <i>Heart Disease</i>	
25. PLACE OF DEATH <i>Home</i>		26. DATE OF DEATH <i>Jan 1, 1958</i>		27. TIME OF DEATH <i>10:00 AM</i>		28. CAUSE OF DEATH <i>Heart Disease</i>	
29. PLACE OF DEATH <i>Home</i>		30. DATE OF DEATH <i>Jan 1, 1958</i>		31. TIME OF DEATH <i>10:00 AM</i>		32. CAUSE OF DEATH <i>Heart Disease</i>	
33. PLACE OF DEATH <i>Home</i>		34. DATE OF DEATH <i>Jan 1, 1958</i>		35. TIME OF DEATH <i>10:00 AM</i>		36. CAUSE OF DEATH <i>Heart Disease</i>	
37. PLACE OF DEATH <i>Home</i>		38. DATE OF DEATH <i>Jan 1, 1958</i>		39. TIME OF DEATH <i>10:00 AM</i>		40. CAUSE OF DEATH <i>Heart Disease</i>	
41. PLACE OF DEATH <i>Home</i>		42. DATE OF DEATH <i>Jan 1, 1958</i>		43. TIME OF DEATH <i>10:00 AM</i>		44. CAUSE OF DEATH <i>Heart Disease</i>	
45. PLACE OF DEATH <i>Home</i>		46. DATE OF DEATH <i>Jan 1, 1958</i>		47. TIME OF DEATH <i>10:00 AM</i>		48. CAUSE OF DEATH <i>Heart Disease</i>	
49. PLACE OF DEATH <i>Home</i>		50. DATE OF DEATH <i>Jan 1, 1958</i>		51. TIME OF DEATH <i>10:00 AM</i>		52. CAUSE OF DEATH <i>Heart Disease</i>	
53. PLACE OF DEATH <i>Home</i>		54. DATE OF DEATH <i>Jan 1, 1958</i>		55. TIME OF DEATH <i>10:00 AM</i>		56. CAUSE OF DEATH <i>Heart Disease</i>	
57. PLACE OF DEATH <i>Home</i>		58. DATE OF DEATH <i>Jan 1, 1958</i>		59. TIME OF DEATH <i>10:00 AM</i>		60. CAUSE OF DEATH <i>Heart Disease</i>	
61. PLACE OF DEATH <i>Home</i>		62. DATE OF DEATH <i>Jan 1, 1958</i>		63. TIME OF DEATH <i>10:00 AM</i>		64. CAUSE OF DEATH <i>Heart Disease</i>	
65. PLACE OF DEATH <i>Home</i>		66. DATE OF DEATH <i>Jan 1, 1958</i>		67. TIME OF DEATH <i>10:00 AM</i>		68. CAUSE OF DEATH <i>Heart Disease</i>	
69. PLACE OF DEATH <i>Home</i>		70. DATE OF DEATH <i>Jan 1, 1958</i>		71. TIME OF DEATH <i>10:00 AM</i>		72. CAUSE OF DEATH <i>Heart Disease</i>	
73. PLACE OF DEATH <i>Home</i>		74. DATE OF DEATH <i>Jan 1, 1958</i>		75. TIME OF DEATH <i>10:00 AM</i>		76. CAUSE OF DEATH <i>Heart Disease</i>	
77. PLACE OF DEATH <i>Home</i>		78. DATE OF DEATH <i>Jan 1, 1958</i>		79. TIME OF DEATH <i>10:00 AM</i>		80. CAUSE OF DEATH <i>Heart Disease</i>	
81. PLACE OF DEATH <i>Home</i>		82. DATE OF DEATH <i>Jan 1, 1958</i>		83. TIME OF DEATH <i>10:00 AM</i>		84. CAUSE OF DEATH <i>Heart Disease</i>	
85. PLACE OF DEATH <i>Home</i>		86. DATE OF DEATH <i>Jan 1, 1958</i>		87. TIME OF DEATH <i>10:00 AM</i>		88. CAUSE OF DEATH <i>Heart Disease</i>	
89. PLACE OF DEATH <i>Home</i>		90. DATE OF DEATH <i>Jan 1, 1958</i>		91. TIME OF DEATH <i>10:00 AM</i>		92. CAUSE OF DEATH <i>Heart Disease</i>	
93. PLACE OF DEATH <i>Home</i>		94. DATE OF DEATH <i>Jan 1, 1958</i>		95. TIME OF DEATH <i>10:00 AM</i>		96. CAUSE OF DEATH <i>Heart Disease</i>	
97. PLACE OF DEATH <i>Home</i>		98. DATE OF DEATH <i>Jan 1, 1958</i>		99. TIME OF DEATH <i>10:00 AM</i>		100. CAUSE OF DEATH <i>Heart Disease</i>	

BUREAU V. S.

JAN 7 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00484

Reg. Dist. No.

491

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mr Army</u>		c. LENGTH OF STAY IN 1b <u>Life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mr Army</u> ✓			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <u>1</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>GEORGE</u> First		<u>ELLSWORTH</u> Middle		4. DATE OF DEATH <u>Jan</u> Month		<u>26</u> Day <u>1958</u> Year	
5. SEX <u>M</u>	6. COLOR OR RACE <u>Cal</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOV 16-1957</u>		9. AGE (In years last birthday) yrs. <u>2</u>	IF UNDER 1 YEAR Months <u>10</u> Days <u>10</u>	IF UNDER 24 HRS. Hours <u>10</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>GEORGE ELLSWORTH COOK Jr.</u>				14. MOTHER'S MAIDEN NAME <u>SHIRLEY ANDERSON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>George Ellsworth Cook Jr</u> Address <u>Mr Army Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>493X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) DUE TO (a), stating the underlying cause last. (c)							INTERVAL BETWEEN ONSET AND DEATH <u>Days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>J. Marsh</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>JAMES T. MARSH</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-28-1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion</u>		22d. LOCATION (City, town, or county) (State) <u>Carroll Co.</u> <u>Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>C.M. Waltz</u>				ADDRESS <u>Winfield. Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 28 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Overman</u>			

2069161XV5

STATE OF
HEALTH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
JAN 28 1953
BUREAU V. S.

1-28-MAX Mt. Zion
Call Smith, Springfield, Ark

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00480

492

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural: Sykesville, Md.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore City</u>			
c. LENGTH OF STAY IN 1b <u>17 days</u>				d. STREET ADDRESS <u>1613 W. 29th. Street, 18</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>Norris</u> Last <u>Cooper</u>				4. DATE OF DEATH Month <u>1</u> Day <u>27</u> Year <u>1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-10-75</u>	
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter Shipwright City Balto.</u>		11. BIRTHPLACE (State or foreign country) <u>Balto. Maryland</u>	
10b. KIND OF BUSINESS OR INDUSTRY				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <u>John Huber Cooper (George W. Cooper)</u>				14. MOTHER'S MAIDEN NAME <u>Mary Gorman ? (Eliza S. Clark)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>Hospital Records Mrs Maud A. Cooper Same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic cardiovascular disease</u> years DUE TO (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Brain Syndrome associated with cerebral arteriosclerosis with psychotic reaction.</u> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u>19</u> p. m. <u> </u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>January 10 1958</u> , to <u>January 27 1958</u> , that I last saw the deceased alive on <u>January 27 1958</u> , and that death occurred at <u>3:10 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Irene L. Hitchman</u>				ADDRESS (Street, city or town, state) <u>Springfield State Hospital</u> DATE SIGNED <u>1-27-58</u>			
PHYSICIAN'S NAME (Type) <u>Irene L. Hitchman, M.D.</u>				M.D. <u>Sykesville, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/29/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mount Olivet Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>HENRY SANDER & SONS INC. BALTIMORE MD.</u>				24a. REC'D BY REGISTRAR <u>JAN 29 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. Beach</u>	

CERTIFICATE OF DEATH

Form 100-100

1. NAME OF DECEASED		2. SEX		3. AGE	
4. RACE		5. BIRTH DATE		6. BIRTH PLACE	
7. MARITAL STATUS		8. OCCUPATION		9. CAUSE OF DEATH	
10. PLACE OF DEATH		11. DATE OF DEATH		12. TIME OF DEATH	
13. SIGNATURE OF PHYSICIAN		14. SIGNATURE OF REGISTRAR		15. SIGNATURE OF WITNESS	
16. SIGNATURE OF DECEASED		17. SIGNATURE OF NEXT OF KIN		18. SIGNATURE OF BURIAL OFFICIAL	
19. SIGNATURE OF FUNERAL HOME		20. SIGNATURE OF CHURCH		21. SIGNATURE OF CEMETERY	
22. SIGNATURE OF MARRIAGE OFFICIAL		23. SIGNATURE OF DIVORCE OFFICIAL		24. SIGNATURE OF PROBATE OFFICIAL	
25. SIGNATURE OF ESTATE OFFICIAL		26. SIGNATURE OF TRUST OFFICIAL		27. SIGNATURE OF GUARDIAN OFFICIAL	
28. SIGNATURE OF ADOPTION OFFICIAL		29. SIGNATURE OF NATURALIZATION OFFICIAL		30. SIGNATURE OF CITIZENSHIP OFFICIAL	
31. SIGNATURE OF RESIDENCE OFFICIAL		32. SIGNATURE OF EMPLOYMENT OFFICIAL		33. SIGNATURE OF EDUCATION OFFICIAL	
34. SIGNATURE OF HEALTH OFFICIAL		35. SIGNATURE OF SOCIAL SECURITY OFFICIAL		36. SIGNATURE OF VETERANS OFFICIAL	
37. SIGNATURE OF POST OFFICE OFFICIAL		38. SIGNATURE OF COURT OFFICIAL		39. SIGNATURE OF JURY OFFICIAL	
40. SIGNATURE OF JUDGE OFFICIAL		41. SIGNATURE OF CLERK OFFICIAL		42. SIGNATURE OF RECEPTION OFFICIAL	
43. SIGNATURE OF RECORDS OFFICIAL		44. SIGNATURE OF INDEXING OFFICIAL		45. SIGNATURE OF FILING OFFICIAL	
46. SIGNATURE OF DISTRIBUTION OFFICIAL		47. SIGNATURE OF RETURN OFFICIAL		48. SIGNATURE OF CLOSING OFFICIAL	
49. SIGNATURE OF DESTRUCTION OFFICIAL		50. SIGNATURE OF REPRODUCTION OFFICIAL		51. SIGNATURE OF REVISION OFFICIAL	
52. SIGNATURE OF CORRECTION OFFICIAL		53. SIGNATURE OF AMENDMENT OFFICIAL		54. SIGNATURE OF SUPPLEMENT OFFICIAL	
55. SIGNATURE OF ADDITION OFFICIAL		56. SIGNATURE OF DELETION OFFICIAL		57. SIGNATURE OF TRANSFER OFFICIAL	
58. SIGNATURE OF ASSIGNMENT OFFICIAL		59. SIGNATURE OF REVOCATION OFFICIAL		60. SIGNATURE OF CANCELLATION OFFICIAL	
61. SIGNATURE OF SUSPENSION OFFICIAL		62. SIGNATURE OF RESTORATION OFFICIAL		63. SIGNATURE OF REINSTATEMENT OFFICIAL	
64. SIGNATURE OF REENTRY OFFICIAL		65. SIGNATURE OF DEPORTATION OFFICIAL		66. SIGNATURE OF EXCLUSION OFFICIAL	
67. SIGNATURE OF INSPECTION OFFICIAL		68. SIGNATURE OF INTERVIEW OFFICIAL		69. SIGNATURE OF INVESTIGATION OFFICIAL	
70. SIGNATURE OF DETENTION OFFICIAL		71. SIGNATURE OF RELEASE OFFICIAL		72. SIGNATURE OF REENTRY OFFICIAL	
73. SIGNATURE OF DEPORTATION OFFICIAL		74. SIGNATURE OF EXCLUSION OFFICIAL		75. SIGNATURE OF INSPECTION OFFICIAL	
76. SIGNATURE OF INTERVIEW OFFICIAL		77. SIGNATURE OF INVESTIGATION OFFICIAL		78. SIGNATURE OF DETENTION OFFICIAL	
79. SIGNATURE OF RELEASE OFFICIAL		80. SIGNATURE OF REENTRY OFFICIAL		81. SIGNATURE OF DEPORTATION OFFICIAL	
82. SIGNATURE OF EXCLUSION OFFICIAL		83. SIGNATURE OF INSPECTION OFFICIAL		84. SIGNATURE OF INTERVIEW OFFICIAL	
85. SIGNATURE OF INVESTIGATION OFFICIAL		86. SIGNATURE OF DETENTION OFFICIAL		87. SIGNATURE OF RELEASE OFFICIAL	
88. SIGNATURE OF REENTRY OFFICIAL		89. SIGNATURE OF DEPORTATION OFFICIAL		90. SIGNATURE OF EXCLUSION OFFICIAL	
91. SIGNATURE OF INSPECTION OFFICIAL		92. SIGNATURE OF INTERVIEW OFFICIAL		93. SIGNATURE OF INVESTIGATION OFFICIAL	
94. SIGNATURE OF DETENTION OFFICIAL		95. SIGNATURE OF RELEASE OFFICIAL		96. SIGNATURE OF REENTRY OFFICIAL	
97. SIGNATURE OF DEPORTATION OFFICIAL		98. SIGNATURE OF EXCLUSION OFFICIAL		99. SIGNATURE OF INSPECTION OFFICIAL	
100. SIGNATURE OF INTERVIEW OFFICIAL		101. SIGNATURE OF INVESTIGATION OFFICIAL		102. SIGNATURE OF DETENTION OFFICIAL	
103. SIGNATURE OF RELEASE OFFICIAL		104. SIGNATURE OF REENTRY OFFICIAL		105. SIGNATURE OF DEPORTATION OFFICIAL	
106. SIGNATURE OF EXCLUSION OFFICIAL		107. SIGNATURE OF INSPECTION OFFICIAL		108. SIGNATURE OF INTERVIEW OFFICIAL	
109. SIGNATURE OF INVESTIGATION OFFICIAL		110. SIGNATURE OF DETENTION OFFICIAL		111. SIGNATURE OF RELEASE OFFICIAL	
112. SIGNATURE OF REENTRY OFFICIAL		113. SIGNATURE OF DEPORTATION OFFICIAL		114. SIGNATURE OF EXCLUSION OFFICIAL	
115. SIGNATURE OF INSPECTION OFFICIAL		116. SIGNATURE OF INTERVIEW OFFICIAL		117. SIGNATURE OF INVESTIGATION OFFICIAL	
118. SIGNATURE OF DETENTION OFFICIAL		119. SIGNATURE OF RELEASE OFFICIAL		120. SIGNATURE OF REENTRY OFFICIAL	
121. SIGNATURE OF DEPORTATION OFFICIAL		122. SIGNATURE OF EXCLUSION OFFICIAL		123. SIGNATURE OF INSPECTION OFFICIAL	
124. SIGNATURE OF INTERVIEW OFFICIAL		125. SIGNATURE OF INVESTIGATION OFFICIAL		126. SIGNATURE OF DETENTION OFFICIAL	
127. SIGNATURE OF RELEASE OFFICIAL		128. SIGNATURE OF REENTRY OFFICIAL		129. SIGNATURE OF DEPORTATION OFFICIAL	
130. SIGNATURE OF EXCLUSION OFFICIAL		131. SIGNATURE OF INSPECTION OFFICIAL		132. SIGNATURE OF INTERVIEW OFFICIAL	
133. SIGNATURE OF INVESTIGATION OFFICIAL		134. SIGNATURE OF DETENTION OFFICIAL		135. SIGNATURE OF RELEASE OFFICIAL	
136. SIGNATURE OF REENTRY OFFICIAL		137. SIGNATURE OF DEPORTATION OFFICIAL		138. SIGNATURE OF EXCLUSION OFFICIAL	
139. SIGNATURE OF INSPECTION OFFICIAL		140. SIGNATURE OF INTERVIEW OFFICIAL		141. SIGNATURE OF INVESTIGATION OFFICIAL	
142. SIGNATURE OF DETENTION OFFICIAL		143. SIGNATURE OF RELEASE OFFICIAL		144. SIGNATURE OF REENTRY OFFICIAL	
145. SIGNATURE OF DEPORTATION OFFICIAL		146. SIGNATURE OF EXCLUSION OFFICIAL		147. SIGNATURE OF INSPECTION OFFICIAL	
148. SIGNATURE OF INTERVIEW OFFICIAL		149. SIGNATURE OF INVESTIGATION OFFICIAL		150. SIGNATURE OF DETENTION OFFICIAL	
151. SIGNATURE OF RELEASE OFFICIAL		152. SIGNATURE OF REENTRY OFFICIAL		153. SIGNATURE OF DEPORTATION OFFICIAL	
154. SIGNATURE OF EXCLUSION OFFICIAL		155. SIGNATURE OF INSPECTION OFFICIAL		156. SIGNATURE OF INTERVIEW OFFICIAL	
157. SIGNATURE OF INVESTIGATION OFFICIAL		158. SIGNATURE OF DETENTION OFFICIAL		159. SIGNATURE OF RELEASE OFFICIAL	
160. SIGNATURE OF REENTRY OFFICIAL		161. SIGNATURE OF DEPORTATION OFFICIAL		162. SIGNATURE OF EXCLUSION OFFICIAL	
163. SIGNATURE OF INSPECTION OFFICIAL		164. SIGNATURE OF INTERVIEW OFFICIAL		165. SIGNATURE OF INVESTIGATION OFFICIAL	
166. SIGNATURE OF DETENTION OFFICIAL		167. SIGNATURE OF RELEASE OFFICIAL		168. SIGNATURE OF REENTRY OFFICIAL	
169. SIGNATURE OF DEPORTATION OFFICIAL		170. SIGNATURE OF EXCLUSION OFFICIAL		171. SIGNATURE OF INSPECTION OFFICIAL	
172. SIGNATURE OF INTERVIEW OFFICIAL		173. SIGNATURE OF INVESTIGATION OFFICIAL		174. SIGNATURE OF DETENTION OFFICIAL	
175. SIGNATURE OF RELEASE OFFICIAL		176. SIGNATURE OF REENTRY OFFICIAL		177. SIGNATURE OF DEPORTATION OFFICIAL	
178. SIGNATURE OF EXCLUSION OFFICIAL		179. SIGNATURE OF INSPECTION OFFICIAL		180. SIGNATURE OF INTERVIEW OFFICIAL	
181. SIGNATURE OF INVESTIGATION OFFICIAL		182. SIGNATURE OF DETENTION OFFICIAL		183. SIGNATURE OF RELEASE OFFICIAL	
184. SIGNATURE OF REENTRY OFFICIAL		185. SIGNATURE OF DEPORTATION OFFICIAL		186. SIGNATURE OF EXCLUSION OFFICIAL	
187. SIGNATURE OF INSPECTION OFFICIAL		188. SIGNATURE OF INTERVIEW OFFICIAL		189. SIGNATURE OF INVESTIGATION OFFICIAL	
190. SIGNATURE OF DETENTION OFFICIAL		191. SIGNATURE OF RELEASE OFFICIAL		192. SIGNATURE OF REENTRY OFFICIAL	
193. SIGNATURE OF DEPORTATION OFFICIAL		194. SIGNATURE OF EXCLUSION OFFICIAL		195. SIGNATURE OF INSPECTION OFFICIAL	
196. SIGNATURE OF INTERVIEW OFFICIAL		197. SIGNATURE OF INVESTIGATION OFFICIAL		198. SIGNATURE OF DETENTION OFFICIAL	
199. SIGNATURE OF RELEASE OFFICIAL		200. SIGNATURE OF REENTRY OFFICIAL		201. SIGNATURE OF DEPORTATION OFFICIAL	
202. SIGNATURE OF EXCLUSION OFFICIAL		203. SIGNATURE OF INSPECTION OFFICIAL		204. SIGNATURE OF INTERVIEW OFFICIAL	
205. SIGNATURE OF INVESTIGATION OFFICIAL		206. SIGNATURE OF DETENTION OFFICIAL		207. SIGNATURE OF RELEASE OFFICIAL	
208. SIGNATURE OF REENTRY OFFICIAL		209. SIGNATURE OF DEPORTATION OFFICIAL		210. SIGNATURE OF EXCLUSION OFFICIAL	
211. SIGNATURE OF INSPECTION OFFICIAL		212. SIGNATURE OF INTERVIEW OFFICIAL		213. SIGNATURE OF INVESTIGATION OFFICIAL	
214. SIGNATURE OF DETENTION OFFICIAL		215. SIGNATURE OF RELEASE OFFICIAL		216. SIGNATURE OF REENTRY OFFICIAL	
217. SIGNATURE OF DEPORTATION OFFICIAL		218. SIGNATURE OF EXCLUSION OFFICIAL		219. SIGNATURE OF INSPECTION OFFICIAL	
220. SIGNATURE OF INTERVIEW OFFICIAL		221. SIGNATURE OF INVESTIGATION OFFICIAL		222. SIGNATURE OF DETENTION OFFICIAL	
223. SIGNATURE OF RELEASE OFFICIAL		224. SIGNATURE OF REENTRY OFFICIAL		225. SIGNATURE OF DEPORTATION OFFICIAL	
226. SIGNATURE OF EXCLUSION OFFICIAL		227. SIGNATURE OF INSPECTION OFFICIAL		228. SIGNATURE OF INTERVIEW OFFICIAL	
229. SIGNATURE OF INVESTIGATION OFFICIAL		230. SIGNATURE OF DETENTION OFFICIAL		231. SIGNATURE OF RELEASE OFFICIAL	
232. SIGNATURE OF REENTRY OFFICIAL		233. SIGNATURE OF DEPORTATION OFFICIAL		234. SIGNATURE OF EXCLUSION OFFICIAL	
235. SIGNATURE OF INSPECTION OFFICIAL		236. SIGNATURE OF INTERVIEW OFFICIAL		237. SIGNATURE OF INVESTIGATION OFFICIAL	
238. SIGNATURE OF DETENTION OFFICIAL		239. SIGNATURE OF RELEASE OFFICIAL		240. SIGNATURE OF REENTRY OFFICIAL	
241. SIGNATURE OF DEPORTATION OFFICIAL		242. SIGNATURE OF EXCLUSION OFFICIAL		243. SIGNATURE OF INSPECTION OFFICIAL	
244. SIGNATURE OF INTERVIEW OFFICIAL		245. SIGNATURE OF INVESTIGATION OFFICIAL		246. SIGNATURE OF DETENTION OFFICIAL	
247. SIGNATURE OF RELEASE OFFICIAL		248. SIGNATURE OF REENTRY OFFICIAL		249. SIGNATURE OF DEPORTATION OFFICIAL	
250. SIGNATURE OF EXCLUSION OFFICIAL		251. SIGNATURE OF INSPECTION OFFICIAL		252. SIGNATURE OF INTERVIEW OFFICIAL	
253. SIGNATURE OF INVESTIGATION OFFICIAL		254. SIGNATURE OF DETENTION OFFICIAL		255. SIGNATURE OF RELEASE OFFICIAL	
256. SIGNATURE OF REENTRY OFFICIAL		257. SIGNATURE OF DEPORTATION OFFICIAL		258. SIGNATURE OF EXCLUSION OFFICIAL	
259. SIGNATURE OF INSPECTION OFFICIAL		260. SIGNATURE OF INTERVIEW OFFICIAL		261. SIGNATURE OF INVESTIGATION OFFICIAL	
262. SIGNATURE OF DETENTION OFFICIAL		263. SIGNATURE OF RELEASE OFFICIAL		264. SIGNATURE OF REENTRY OFFICIAL	
265. SIGNATURE OF DEPORTATION OFFICIAL		266. SIGNATURE OF EXCLUSION OFFICIAL		267. SIGNATURE OF INSPECTION OFFICIAL	
268. SIGNATURE OF INTERVIEW OFFICIAL		269. SIGNATURE OF INVESTIGATION OFFICIAL		270. SIGNATURE OF DETENTION OFFICIAL	
271. SIGNATURE OF RELEASE OFFICIAL		272. SIGNATURE OF REENTRY OFFICIAL		273. SIGNATURE OF DEPORTATION OFFICIAL	
274. SIGNATURE OF EXCLUSION OFFICIAL		275. SIGNATURE OF INSPECTION OFFICIAL		276. SIGNATURE OF INTERVIEW OFFICIAL	
277. SIGNATURE OF INVESTIGATION OFFICIAL		278. SIGNATURE OF DETENTION OFFICIAL		279. SIGNATURE OF RELEASE OFFICIAL	
280. SIGNATURE OF REENTRY OFFICIAL		281. SIGNATURE OF DEPORTATION OFFICIAL		282. SIGNATURE OF EXCLUSION OFFICIAL	
283. SIGNATURE OF INSPECTION OFFICIAL		284. SIGNATURE OF INTERVIEW OFFICIAL		285. SIGNATURE OF INVESTIGATION OFFICIAL	
286. SIGNATURE OF DETENTION OFFICIAL		287. SIGNATURE OF RELEASE OFFICIAL		288. SIGNATURE OF REENTRY OFFICIAL	
289. SIGNATURE OF DEPORTATION OFFICIAL		290. SIGNATURE OF EXCLUSION OFFICIAL		291. SIGNATURE OF INSPECTION OFFICIAL	
292. SIGNATURE OF INTERVIEW OFFICIAL		293. SIGNATURE OF INVESTIGATION OFFICIAL		294. SIGNATURE OF DETENTION OFFICIAL	
295. SIGNATURE OF RELEASE OFFICIAL		296. SIGNATURE OF REENTRY OFFICIAL		297. SIGNATURE OF DEPORTATION OFFICIAL	
298. SIGNATURE OF EXCLUSION OFFICIAL		299. SIGNATURE OF INSPECTION OFFICIAL		300. SIGNATURE OF INTERVIEW OFFICIAL	

BUREAU V. 2

JAN 26 1953

RECEIVED

493

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Balto. City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 14			
c. LENGTH OF STAY IN TB 1yr. 9mos. 4days				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS 2325 Foster Ave.			
3. NAME OF DECEASED (Type or print) First Viola Middle Elizabeth S. Last COOPER				4. DATE OF DEATH Month January Day 27 Year 1958			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH September 24, 1884		9. AGE (In years last birthday) 73 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Wash., D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Zachary T. Simmons				14. MOTHER'S MAIDEN NAME Lillian McGee			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -		17. INFORMANT Springfield Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Psychotic Depressive Reaction						INTERVAL BETWEEN ONSET AND DEATH 3-4 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 23, 1956 , to January 27, 1958 , that I last saw the deceased alive on January 26, 1958 , and that death occurred at 1:05 A M , from the causes and on the date stated above.							
ACTUAL SIGNATURE Agustin del Campo				ADDRESS (Street, city or town, state) Springfield State Hospital			
PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.				DATE SIGNED 1/27/58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/30/58		22c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Brock-Blight, Jr.				ADDRESS 6009 Hayford Rd.		24a. REC'D BY REGISTRAR DATE JAN 28 1958	
				24b. REGISTRAR'S SIGNATURE Art. Leach			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH	
JAMES H. HARRIS		Male		45		1888	
PLACE OF BIRTH		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
Baltimore, Md.		Carpenter		Heart Disease		Natural	
DATE OF DEATH		PLACE OF DEATH		DATE OF BURIAL		PLACE OF BURIAL	
Jan 28, 1933		Baltimore, Md.		Jan 30, 1933		Baltimore, Md.	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED	
J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
Jan 28, 1933		Jan 28, 1933		Jan 28, 1933		Jan 28, 1933	

BUREAU V. S.

JAN 30 1933

RECEIVED

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Taneytown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Taneytown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>W. Baltimore Street</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Elmer</u> Middle <u>E.</u> Last <u>Crebs</u>		4. DATE OF DEATH Month <u>January</u> Day <u>6</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 25, 1876</u>
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Supt.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>City Water Dept.</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William E. Crebs</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Dayhoff</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>212-24-3017</u>	
17. INFORMANT <u>Mrs. Helen Hilterbrick, Taneytown, Maryland</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the Prostate with</u> <u>177X</u> DUE TO (b) <u>metastasis</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (c) _____ DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>2 1/4 yrs</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Date nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept 22</u> , 19 <u>55</u> , to <u>Jan 6</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Jan 6</u> , 19 <u>58</u> , and that death occurred at <u>11:50A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Charles R Williams M.D. Emmitsburg, Md 1-8-58</u>			
ACTUAL SIGNATURE <u>Charles R Williams</u>		PHYSICIAN'S NAME (Type) <u>Charles R Williams</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/9/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Reformed Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Taneytown, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>C.O. Fuss & Son, Taneytown, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 9 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Alfred</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1958-04-11



BUREAU V. 3

JAN 9 1959

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

495

CERTIFICATE OF DEATH

00488

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>CARROLL</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NEW WINDSOR</u> c. LENGTH OF STAY IN 1b <u>YEARS</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HIGH ST</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NEW WINDSOR</u> d. STREET ADDRESS <u>HIGH ST</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>FLORENCE A. CURREY</u>		4. DATE OF DEATH Month <u>JAN</u> Day <u>23</u> Year <u>1958</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 30-1891</u>
9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEKEEPER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>WILLIAM R. CURREY</u>		14. MOTHER'S MAIDEN NAME <u>ELIZABETH BARNES</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>GEORGE MILLER</u>		Address <u>NEW WINDSOR MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>arteriosclerotic Cardiovascular disease</u> DUE TO (c) <u>disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>2/15/57</u> 19 , to <u>1/23/58</u> , 19 , that I last saw the deceased alive on <u>1/22/58</u> , 19 , and that death occurred at <u>4 P. M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>New Windsor Md</u> DATE SIGNED <u>1/23/58</u>			
ACTUAL SIGNATURE <u>M. E. Robertson</u> M.D.		PHYSICIAN'S NAME (Type) <u>M. E. ROBERTSON</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JAN 25-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>PRESBYTERIAN CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>NEW WINDSOR MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>D. D. Hartzler</u> ADDRESS <u>New Windsor, Md</u>		24a. REC'D BY REGISTRAR <u> </u> DATE <u>JAN 27 '58</u>	
24b. REGISTRAR'S SIGNATURE <u> </u>			

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTRY OF BIRTH	
MARRIED		SINGLE		WIDOWED		DIVORCED		DATE OF MARRIAGE		PLACE OF MARRIAGE		CITY OF MARRIAGE		COUNTRY OF MARRIAGE	
OCCUPATION		EDUCATION		RELIGION		MILITARY SERVICE		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH	
CAUSE OF DEATH		MANNER OF DEATH		IMMEDIATE CAUSE		UNDERLYING CAUSE		DATE OF EXAMINATION		PLACE OF EXAMINATION		CITY OF EXAMINATION		COUNTRY OF EXAMINATION	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF JURY		SIGNATURE OF WITNESSES		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF CLERK		SIGNATURE OF REGISTRAR	

BUREAU V. S.

JAN 27 1939

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00489

496

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Sykesville		c. LENGTH OF STAY IN 1b since 4-11-29	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Frederick		d. STREET ADDRESS 108-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Vernon Middle W. Last DAVIS		4. DATE OF DEATH Month January Day 16 Year 1958	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-4-77
9. AGE (In years last birthday) 80 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months — Days — Hours — Min. —	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (State or foreign country) Frederick, Maryland		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME George W. Davis		14. MOTHER'S MAIDEN NAME Mary E. Price	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Records of Springfield State Hospital		Address Sykesville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchial Pneumonia (primary) DUE TO 422.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardiovascular Disease DUE TO more than 14. (c) 1 week		INTERVAL BETWEEN ONSET AND DEATH more than 14.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Manic depressive psychosis, depressed type		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ---	
20c. TIME OF INJURY Month, Day, Year Hour a. m. --- p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ---		20f. (City or town) (County) (State) ---	
21. I certify that I attended the deceased from Jan 11 , 19 58 , to January 15 , 19 58 , that I last saw the deceased alive on January 15 , 19 58 , and that death occurred at 9:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 1/16/58 ACTUAL SIGNATURE Walter Knopp M.D. Springfield State Hospital PHYSICIAN'S NAME (Type) Walter Knopp, M. D. Sykesville, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-20-58	
22c. NAME OF CEMETERY OR CREMATORY Christian Cemetery		22d. LOCATION (City, town, or county) (State) Hyattstown, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		24a. REC'D BY REGISTRAR DATE JAN 20 '58	
24b. REGISTRAR'S SIGNATURE W. H. Smith			

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, cause of death, and location. The form is oriented horizontally but contains vertical text labels for various fields.

BUREAU V. S.

JAN 20 1938

RECEIVED

497

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Airy-Rural-R.D.#3				c. LENGTH OF STAY IN 1b Years			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Airy-Rural-R.D.#3				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Near Ridgeville			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				d. STREET ADDRESS Near Ridgeville			
3. NAME OF DECEASED (Type or print) First HELENA Middle CHRISTINA Last DECKER				4. DATE OF DEATH Month January Day 20 Year 1958			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 26, 1906	
9. AGE (In years last birthday) 51 yrs.		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.		IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Domestic		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Eugene A. Roelke				14. MOTHER'S MAIDEN NAME Susan Rickerd			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Mr. Melvin H. Decker, Sr., Mt. Airy R.D.#3, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Liver with General Metastasis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) General Metastasis DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Aug 1957 to Jan 20, 1958 that I last saw the deceased alive on Jan 20, 1958 and that death occurred at 10:15 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE C. M. Van Poole M.D.				ADDRESS (Street, city or town, State) Mt. Airy Rd DATE SIGNED 1-20-58			
PHYSICIAN'S NAME (Type) C. M. Van Poole							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 23, 1958		22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland				24a. REC'D BY REGISTRAR DATE JUN 22 '58		24b. REGISTRAR'S SIGNATURE W. L. Leach	

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Manner of Death		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
John A. Smith		Male		45		1910-10-15		Baltimore, Md.		Natural		Heart Disease		1955-12-20		10:00 AM		Home		J. A. Smith		J. A. Smith	
Name of Informant		Relationship		Address		City		State		County		Zip		Date of Report		Time of Report		Place of Report		Signature of Informant		Signature of Registrar	
John A. Smith		Son		1234 Main St.		Baltimore		Md.		Baltimore		21201		1956-01-05		10:00 AM		Home		J. A. Smith		J. A. Smith	
Name of Informant		Relationship		Address		City		State		County		Zip		Date of Report		Time of Report		Place of Report		Signature of Informant		Signature of Registrar	
John A. Smith		Son		1234 Main St.		Baltimore		Md.		Baltimore		21201		1956-01-05		10:00 AM		Home		J. A. Smith		J. A. Smith	

BUREAU V. S.

JAN 22 1956

RECEIVED

498

CERTIFICATE OF DEATH

00491

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY CAROLL MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BA			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SYKESVILLE MD				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE 3V01-4			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRINGFIELD STATE HOSPITAL SYKESVILLE				d. STREET ADDRESS 5107 HERRING RUN			
3. NAME OF DECEASED (Type of name) UNKNOWN (KATIE) KATHARINA DENNY BUSCHE DENNY				4. DATE OF DEATH Month JANUARY Day 11 Year 1958			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-15-1870-71		9. AGE (In years last birthday) 87-88		10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) GERMANY		12. CITIZEN OF WHAT COUNTRY? AMERICAN	
13. FATHER'S NAME SAVIX BOSCH				14. MOTHER'S MAIDEN NAME SUSAN WALZAN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Address BALTIMORE Mrs ROSE KAUFMAN 5107 Herring Run			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE (c) GENERALIZED ARTERIOSCLEROSIS INTERVAL BETWEEN ONSET AND DEATH 2 DAYS MONTHS YEARS						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 491X							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8-11 19 54 , to 1-11 19 58 , that I last saw the deceased alive on 1-10 19 58 , and that death occurred at 7:45 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Gertud Sonnenfeldt M.D. Springfield State Hospital, Sykesville Md.							
PHYSICIAN'S NAME (Type) SONNENFELDT Gertud M.D. Springfield State Hospital Sykesville Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 1-13-58		22c. NAME OF CEMETERY OR CREMATORY Prospect Hill		22d. LOCATION (City, town, or county) (State) Washington - DC	
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Rock 5305 Hartford ADDRESS				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
				DATE JAN 14 '58			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

CERTIFICATE OF DEATH

00492

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>CARROLL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>CARROLL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>48 LIBERTY ST</u>				d. STREET ADDRESS <u>48 LIBERTY ST</u>			
3. NAME OF DECEASED (Type or print) <u>CASSIE</u> First Middle Last				4. DATE OF DEATH <u>JAN 3</u> Month Day Year <u>1958</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-28-1865</u>		9. AGE (In years last birthday) <u>92</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MD.</u>	
13. FATHER'S NAME <u>JOHN DRISCOLL</u>				14. MOTHER'S MAIDEN NAME <u>MARY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NONE</u>				16. SOCIAL SECURITY NO. <u>NONE</u>			
17. INFORMANT <u>MRS GABRIEL KOONTZ WESTMINSTER MD.</u>				Address <u>48 LIBERTY ST.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio Vascular Renal Disease</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Senility Pernicious Anemia</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>54 yrs</u> <u>20 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>June 1940</u> to <u>June 3, 1958</u> , that I last saw the deceased alive on <u>June 3, 1958</u> , and that death occurred at <u>11:00 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W. Glenn Speicher</u> M.D.				ADDRESS (Street, city or town, state) <u>Westminster Md</u>			
PHYSICIAN'S NAME (Type) <u>W. Glenn Speicher</u>				DATE SIGNED <u>1/6/58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1-7-1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ST. JOHNS CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>WESTMINSTER MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>David C. Bamford Westminster Md.</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 21 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. Beach</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH	
JAMES H. HARRIS		M		45		JAN 15 1905	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		PLACE OF DEATH	
1234 E. BALTIMORE ST.		LABORER		HEART DISEASE		HOME	
DATE OF DEATH		TIME OF DEATH		PLACE OF INTERMENT		NAME OF MINISTER	
JAN 20 1955		10:30 AM		CATHOLIC CHURCH		FR. J. J. HARRIS	
SIGNATURE OF PHYSICIAN		SIGNATURE OF MINISTER		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESSES	
J. J. HARRIS		J. J. HARRIS		J. J. HARRIS		J. J. HARRIS	

BUREAU V. S.

JAN 21 1955

RECEIVED

499

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Balto. City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 19yrs. 11mos. 13days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. STREET ADDRESS 3314 O'Donnell Street							
3. NAME OF DECEASED (Type or print) First George Middle J. Last EBERT				4. DATE OF DEATH Month January Day 23, Year 1958			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October, 1889	
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months 68 Days 68 Hours 68 Min.		IF UNDER 24 HRS. Months 68 Days 68 Hours 68 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Advertising Business				10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME John Ebert				14. MOTHER'S MAIDEN NAME Mary Steinberger			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. -		17. INFORMANT Springfield Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Epidermoid carcinoma of tonsil DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 145.0 (c) 145.0 DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. associated with intoxication, alcohol intoxication, with psychotic reaction. INTERVAL BETWEEN ONSET AND DEATH Months							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Springfield State Hospital				20g. (County) Sykesville		20h. (State) Maryland	
21. I certify that I attended the deceased from March 7, 19 55 , to January 23, 19 58 , that I last saw the deceased alive on January 22, 19 58 , and that death occurred at 4:30A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 1/23/58							
ACTUAL SIGNATURE Agustin del Campo				PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				22b. DATE THEREOF 1-26-58		22c. NAME OF CEMETERY OR CREMATORY SACRED HEART CEM. 1401 GERMAN HILL RD., MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles S. Z...				24a. REC'D BY REGISTRAR 24		24b. REGISTRAR'S SIGNATURE ...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DEATH NO. 1938		COUNTY OF BALTIMORE	
NAME OF DECEASED JOHN V. BUREAU		SEX MALE	
AGE 57		DATE OF BIRTH JAN 27 1881	
PLACE OF BIRTH BALTIMORE, MD		OCCUPATION LABORER	
MARITAL STATUS SINGLE		CAUSE OF DEATH HEART DISEASE	
DATE OF DEATH JAN 27 1938		TIME OF DEATH 10:00 AM	
PLACE OF DEATH HOME		SIGNATURE OF DECEASED (None)	
SIGNATURE OF WITNESS (None)		SIGNATURE OF PHYSICIAN (None)	
SIGNATURE OF CLERK (None)		SIGNATURE OF REGISTRAR (None)	

BUREAU V. B.

JAN 27 1938

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00494

500

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Union Bridge</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Union Bridge</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address OR INSTITUTION) <u>Main St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>BERNARD</u> Middle <u>ROBERT</u> Last <u>ETZLER</u>		4. DATE OF DEATH Month <u>Jan</u> Day <u>14</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT. 14 1886</u>
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMER</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>JAMES ETZLER</u>		14. MOTHER'S MAIDEN NAME <u>LAURA CARTER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>213-24-8244</u>	
17. INFORMANT <u>EDNA ETZLER</u> Address <u>Union Bridge Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Diabetic Coma</u> <u>260X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Diabetes Mellitus</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Sept 6, 1957</u> , to <u>1-14, 1958</u> , that I last saw the deceased alive on <u>1-14, 1958</u> , and that death occurred at <u>12:30 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. H. Legg</u>		M.D. <u>Union Bridge Md.</u> DATE SIGNED <u>1-14-58</u>	
PHYSICIAN'S NAME (Type) <u>T.H. Legg</u>		<u>Union Bridge, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>1/16/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>LUTHERAN</u>	22d. LOCATION (City, town, or county) (State) <u>Union Town Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>D.D. Hartzler</u> ADDRESS <u>Union Bridge Md</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 17 1958</u>	24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

501

CERTIFICATE OF DEATH

Reg. Dist. No.

00495

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Balto. City</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>533 Benninghaus Rd.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hospital</u>		d. STREET ADDRESS <u>Baltimore 12, Md.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Lillian Ann Insley EVANS</u>		4. DATE OF DEATH Month Day Year <u>January 17, 19 58</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>January 30, 1887</u>
9. AGE (In years last birthday) yrs. <u>70</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Winfield Insley</u>		14. MOTHER'S MAIDEN NAME <u>Josephine Insley</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Springfield Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive cardiovascular disease</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>C.B.S. assoc. with cerebral arteriosclerosis with psychotic reaction.</u> <u>Diabetes Mellitus</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>December 31, 1957</u> , to <u>January 17, 1958</u> , that I last saw the deceased alive on <u>January 17, 1958</u> , and that death occurred at <u>1:45P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Edmund Lusthaus</u> Edmund Lusthaus, M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>Springfield State Hospital</u> <u>1/17/58</u>	
PHYSICIAN'S NAME (Type) <u>Edmund Lusthaus</u>		<u>Sykesville, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>1/20/58</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Balto Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lernard J. Luck</u>		ADDRESS <u>5300 Harford</u>	
24a. REC'D BY REGISTRAR DATE <u>JAN 20 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. L. Smith</u>	

502

CERTIFICATE OF DEATH

00496

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Sykesville				c. LENGTH OF STAY IN 1b since 5-7-57			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First James Middle Edward Last EVELY				4. DATE OF DEATH Month January Day 14 Year 1958			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 12, 1870	
9. AGE (In years last birthday) 87 yrs.		IF UNDER 1 YEAR Months — Days — Hours — Min. —		IF UNDER 24 HRS. Months — Days — Hours — Min. —			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Mt. Airy, Maryland		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME George Evelyn				14. MOTHER'S MAIDEN NAME Lizzie Poole			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Records of Springfield State Hospital			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis (severe) DUE TO (c) Chronic brain syndrome associated with circulatory disturbance, with cerebral arterio sclerosis, with psychotic reaction.						INTERVAL BETWEEN ONSET AND DEATH 1 day many years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic brain syndrome associated with circulatory disturbance, with cerebral arterio sclerosis, with psychotic reaction.						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 490X		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 490X		20c. TIME OF INJURY Hour — a. m. — p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —		20f. (City or town) —		(County) —		(State) —	
21. I certify that I attended the deceased from July 16 , 19 57 , to Jan. 14 , 19 58 , that I last saw the deceased alive on January 14 , 19 58 , and that death occurred at 2:25 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 1/14/58							
ACTUAL SIGNATURE Walter Knopp		M.D. Springfield State Hospital					
PHYSICIAN'S NAME (Type) Walter Knopp, M. D.		Sykesville, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 17, 58		22c. NAME OF CEMETERY OR CREMATORY Ethison Meth.		22d. LOCATION (City, town, or county) (State) Ethison Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Roy W Barber				ADDRESS Sykesville, Md.		24a. REC'D BY REGISTRAR —	
				24b. REGISTRAR'S SIGNATURE —		DATE JAN 16 '58	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

CERTIFICATE OF DEATH

Page One of Two

BUREAU V. 8

JAN 16 1938

RECEIVED

Jan 18 1938

RECEIVED
JAN 18 1938
BALTIMORE

503

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Eldersburg</u>				c. LENGTH OF STAY IN 1b <u>1 yr.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>-</u>				d. STREET ADDRESS <u>New Windsor</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>SAMUEL</u> Middle <u>J</u> Last <u>FOGLE</u>				4. DATE OF DEATH Month <u>Jan</u> Day <u>14</u> Year <u>1958</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 11, 1864</u>		9. AGE (In years last birthday) <u>93</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own business</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John W. Fogle</u>				14. MOTHER'S MAIDEN NAME <u>Cenia Hyder</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>578-26-3199</u>		17. INFORMANT <u>Mr. Charles J. Fogle, Sykesville, P.O. 3, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest, Cerebral hemorrhage,</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>right hemiplegia, arteriosclerosis generalized</u> DUE TO (c) <u>arteriosclerotic heart disease</u> INTERVAL BETWEEN ONSET AND DEATH <u>July 57 To 14 Jan 58</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July</u> , 19 <u>57</u> , to <u>14 Jan</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>14 Jan</u> , 19 <u>58</u> , and that death occurred at <u>11:20 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Howard E. Hall</u> M.D.				ADDRESS (Street, city or town, state) <u>Sykesville, Md.</u> DATE SIGNED <u>14 Jan 58</u>			
PHYSICIAN'S NAME (Type) <u>HOWARD E. HALL</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan 16, '58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Beaver Dam</u>		22d. LOCATION (City, town, or county) (State) <u>W. Johnsville, Ind. Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Gib Barton</u> ADDRESS <u>Walker, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 17 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. E. ...</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

1953 JAN 17

RECEIVED

504 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Balto. City		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville			c. LENGTH OF STAY IN 1b 3yrs. 6days		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital			d. STREET ADDRESS 2717 Pelham Ave., Zone 13		
3. NAME OF DECEASED (Type or print) First Arthur Middle Thomas Last FOSTER			4. DATE OF DEATH Month January Day 7 Year 19 58		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 15, 1868		9. AGE (In years last birthday) yrs. 89
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY B & O. R. R.		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME James H. Foster		
14. MOTHER'S MAIDEN NAME Mattie H. Harriett Chandler			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) -		
16. SOCIAL SECURITY NO. -			17. INFORMANT Springfield Hospital Records		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarct 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary occlusion DUE TO (c) Arteriosclerotic heart disease					INTERVAL BETWEEN ONSET AND DEATH 17 days 17 days Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with dist. of metabolism, growth or nutrition, with psychotic reaction.					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Dec. 31, 19 54 , to January 7, 19 58 , that I last saw the deceased alive on January 6, 19 58 , and that death occurred at 1:00A. M. from the causes and on the date stated above.					
ACTUAL SIGNATURE Walther H. Sonnenfeldt		M.D. Springfield State Hospital		DATE SIGNED 1/7/58	
PHYSICIAN'S NAME (Type) Walther H. Sonnenfeldt, M.D.		ADDRESS (Street, city or town, state) Sykesville, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/9/58	22c. NAME OF CEMETERY OR CREMATORY Parkwood Cem.		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Schimunek			ADDRESS 3331 Brehms Lane		24a. REC'D BY REGISTRAR DATE JAN 9 '58
			24b. REGISTRAR'S SIGNATURE W. H. Schimunek		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED [REDACTED]		2. SEX [REDACTED]		3. RACE [REDACTED]		4. DATE OF BIRTH [REDACTED]		5. PLACE OF BIRTH [REDACTED]	
6. MARITAL STATUS [REDACTED]		7. OCCUPATION [REDACTED]		8. CAUSE OF DEATH [REDACTED]		9. MANNER OF DEATH [REDACTED]		10. PLACE OF DEATH [REDACTED]	
11. DATE OF DEATH [REDACTED]		12. TIME OF DEATH [REDACTED]		13. SIGNATURE OF DECEASED [REDACTED]		14. SIGNATURE OF WITNESS [REDACTED]		15. SIGNATURE OF PHYSICIAN [REDACTED]	
16. SIGNATURE OF CORONER [REDACTED]		17. SIGNATURE OF JURY [REDACTED]		18. SIGNATURE OF JUDGE [REDACTED]		19. SIGNATURE OF CLERK [REDACTED]		20. SIGNATURE OF REGISTRAR [REDACTED]	

BUREAU V. 2

JAN 9 1953

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

505 CERTIFICATE OF DEATH

00499

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. * If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville	c. LENGTH OF STAY IN 1b 5 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓ Cockeysville (rural) 03X	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pullen Nursing Home		d. STREET ADDRESS Falls Rd.	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Irene Middle Florence Last Fowble		4. DATE OF DEATH Month Jan. Day 28 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-31-1870
9. AGE (In years last birthday) yrs. 87		IF UNDER 1 YEAR Months 8 Days 28 Hours 19 Min.	IF UNDER 24 HRS. Months 8 Days 28 Hours 19 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY home	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME J. Best Cole		14. MOTHER'S MAIDEN NAME Nancy Wheeler	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no.		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs. Grace Akehurst, Monkton, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Decompensation 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic C-V. Disease DUE TO 1 1/2 yrs. Interval between onset and death 2 wks.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) none		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none	
20c. TIME OF INJURY Month, Day, Year Hour o. m. none p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> none	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) (County) (State) none	
21. I certify that I attended the deceased from Jan. 19 , 19 58 , to Jan. 28 , 19 58 , that I last saw the deceased alive on Jan. 27 , 19 58 , and that death occurred at 8:30 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6 Hanover Rd. Reisterstown, Md. DATE SIGNED 1-28-58			
ACTUAL SIGNATURE D. D. Caples		M.D. 6 Hanover Rd. Reisterstown, Md.	
PHYSICIAN'S NAME (Type) D. D. Caples, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1-31-58	22c. NAME OF CEMETERY OR CREMATORY Black Rock	22d. LOCATION (City, town, or county) (State) Butler, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE J. Scott Brooks		24a. REC'D BY REGISTRAR DATE JAN 31 '58	
ADDRESS 622 York Rd., Towson 4, Md.		24b. REGISTRAR'S SIGNATURE W. F. Smith	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00500

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY CARROLL MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY FREDERICK	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TANEYTOWN		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL EMMITSBURG 10X-2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) HANOVER ST.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JAMES First FRANK Middle GARBER Last		4. DATE OF DEATH JAN Month 14 Day 1958 Year	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG 16 - 1899
9. AGE (In years last birthday) 58 yrs.		10. IF UNDER 1 YEAR: Months 5 Days 14 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DAY WORKER		10b. KIND OF BUSINESS OR INDUSTRY RUBBER FACTORY	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME SAMUEL GARBER		14. MOTHER'S MAIDEN NAME CARRIE OGLE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 214-28-0047	
17. INFORMANT MRS CARROLL WICKLESS		Address WOODS BORO MD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH min			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James J. Marsh		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) JAMES T. MARSH		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 1/17/58	
22c. NAME OF CEMETERY OR CREMATORY MT HOPE		22d. LOCATION (City, town, or county) (State) WOODS BORO MD	
23. FUNERAL DIRECTOR'S SIGNATURE POWELL HARTZLER		24a. REC'D BY REGISTRAR JAN 17 '58	
ADDRESS WOODS BORO MD		24b. REGISTRAR'S SIGNATURE Al Lewis	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JAN 17 1938

BUREAU V. S.

STATE OF MARYLAND
DEPARTMENT OF HEALTH - BALTIMORE 10
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED: [illegible]
AGE: [illegible]
SEX: [illegible]
RACE: [illegible]
DATE OF BIRTH: [illegible]
PLACE OF BIRTH: [illegible]
DATE OF DEATH: [illegible]
PLACE OF DEATH: [illegible]
CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]
SIGNATURE OF EXAMINER: [illegible]
DATE: [illegible]

FOR STATE
HEALTH DEPT

507

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL NEW WINDSOR</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL NEW WINDSOR</u>			
c. LENGTH OF STAY IN 1b <u>YEARS</u>				d. STREET ADDRESS <u>1</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>NATHANIEL EARL GARRETT</u>				4. DATE OF DEATH Month <u>JAN</u> Day <u>11</u> Year <u>1958</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>COL</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/15/1880</u>	
9. AGE (In years last birthday) <u>77</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>UNKNOWN</u>		11. BIRTHPLACE (State or foreign country) <u>JAMAICA WEST INDIES</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>UNKNOWN</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>213-14-3515A</u>		17. INFORMANT <u>MRS MARY MEGENHARDT</u>		Address <u>RURAL NEW WINDSOR</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Decompensation</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertension</u> DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>X</u>		20c. TIME OF INJURY Month <u>X</u> Day <u>19</u> Hour <u>a. m.</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>X</u>	
20f. (City or town) <u>X</u>		(County) <u>X</u>		(State) <u>X</u>		21. I certify that I attended the deceased from <u>May 7</u> , 1958, to <u>1-11</u> , 1958 that I last saw the deceased alive on <u>19</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.	
ACTUAL SIGNATURE <u>N. C. Stone</u>		M.D. <u>125 E. Federal</u>		ADDRESS (Street, city or town, state) <u>Frederick Co MD</u>		DATE SIGNED <u>125 E. Federal</u>	
PHYSICIAN'S NAME (Type) <u>N. C. Stone</u>		22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1/7/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MT OLIVE</u>	
22d. LOCATION (City, town, or county) <u>FREDERICK CO MD</u>		(State) <u>MD</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>DR Hartzler & Sons</u>		ADDRESS <u>New Windsor Md</u>	
24a. REC'D BY REGISTRAR DATE <u>JAN 15 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. Beach</u>		24c. REGISTRAR'S SIGNATURE <u>W. Beach</u>		24d. REGISTRAR'S SIGNATURE <u>W. Beach</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

[illegible]

AN 15 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

508

CERTIFICATE OF DEATH

00502

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>City</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 18, Md.</u> 3V01-F			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hospital</u>				d. STREET ADDRESS <u>2056 Kennedy Avenue</u>			
3. NAME OF DECEASED (Type or print) First <u>Howell</u> Middle <u>Reese</u> Last <u>Gatchell</u>				4. DATE OF DEATH Month <u>1</u> Day <u>18</u> Year <u>1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-20-81</u>	
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bookkeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>John Howell Gatchell</u>				14. MOTHER'S MAIDEN NAME <u>Hettie Maria Reese</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>unkn</u>		17. INFORMANT <u>Spr. St. Hospital Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriolar nephrosclerosis</u> <u>442x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u> </u> days <u> </u> years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chr. brain syndr. assoc. with senile brain disease with psych. reaction</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. <u> </u> <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>							
21. I certify that I attended the deceased from <u>12-27-57</u> to <u>1-17-</u> <u>1958</u> , that I last saw the deceased alive on <u>1-17-</u> <u>1958</u> , and that death occurred at <u>1:30 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Edmund Lusthaus</u> M.D.				ADDRESS (Street, city or town, state) <u>Springfield State Hospital</u>			
DATE SIGNED <u>1-18-58</u>							
PHYSICIAN'S NAME (Type) <u>Edmund Lusthaus M.D.</u> <u>Sykesville, Maryland.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan. 20, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Green Mount</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John O. Mitchell & Sons Inc. 1900 Eutaw Pl. Balto</u>				ADDRESS <u> </u>		24a. REC'D BY REGISTRAR <u> </u> DATE <u> </u>	
24b. REGISTRAR'S SIGNATURE <u> </u>							

BUREAU V. S.

JAN 20 1953

RECEIVED

509 CERTIFICATE OF DEATH

Reg. Dist. No.

00503

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City 5 3001.4 ✓			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS 615 No. Highland Ave.			
3. NAME OF DECEASED (Type or print) First Irene Middle Lillian Last Habicht				4. DATE OF DEATH Month 1 Day 4 Year 1958			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 5, 1897	9. AGE (In years last birthday) 60 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Grocery clerk		10b. KIND OF BUSINESS OR INDUSTRY Store		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Jones				14. MOTHER'S MAIDEN NAME Annie Hines			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 219-32-1976		17. INFORMANT Address Springfield Hospital records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Cardiovascular Accident 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral thrombosis DUE TO (c) generalized Arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH 4 days weeks years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic brain syndrome associated with cerebral arteriosclerosis with psychotic reaction							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from February 15, 1957 to 1-4 , 19 58 , that I last saw the deceased alive on 1-3 , 19 58 , and that death occurred at 6:10 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Gertrud Sonnenfeldt M.D. Springfield State Hospital Sykesville Md.							
PHYSICIAN'S NAME (Type) GERTRUD SONNENFELDT, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-7-58		22c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cem.		22d. LOCATION (City, town, or county) (State) Baltimore-Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS John C. Miller Inc.-2431 E. Oliver St.				24a. REC'D BY REGISTRAR DATE JAN 8 '58		24b. REGISTRAR'S SIGNATURE Deborah	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, cause of death, and location. The form is partially filled out with handwritten text.

BUREAU V. 2

JAN 8 1953

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00504

510

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Balto. City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 20yrs. 10mos. 23 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last George Ernest HALL				4. DATE OF DEATH Month Day Year January 13, 1958			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 29, 1878	
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Race Track Official				10b. KIND OF BUSINESS OR INDUSTRY Racing		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Charles C. Hall				14. MOTHER'S MAIDEN NAME Margaret Todd			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		(If yes, give war or dates of service)		16. SOCIAL SECURITY NO. -		17. INFORMANT Springfield Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 446x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Senile arteriosclerotic nephrosclerosis DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH Days Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Manic Depressive Reaction, manic type.							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Springfield State Hospital				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from July 1, 1950 , to January 13, 1958 , that I last saw the deceased alive on January 12, 1958 , and that death occurred at 7:45 A. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE W. H. Sonnenfeldt				ADDRESS (Street, city or town, state) Springfield State Hospital			
DATE SIGNED 1/13/58							
PHYSICIAN'S NAME (Type) Walther H. Sonnenfeldt, M.D. Sykesville, Maryland.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/15/58		22c. NAME OF CEMETERY OR CREMATORY Mount Olivet		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Means and Son				ADDRESS 805 N. Calvert St.		24a. REC'D BY REGISTRAR DATE JAN 15 '58	
				24b. REGISTRAR'S SIGNATURE W. W. Means			

511

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Airy	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pullen Nursing Home		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First EMORY Middle A. Last HARRISON		4. DATE OF DEATH Month JAN. Day 25, Year 1958	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-14-1973
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired farmer		10b. KIND OF BUSINESS OR INDUSTRY owner	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME George W. Harrison	
14. MOTHER'S MAIDEN NAME Jane Gosnell		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. ---		17. INFORMANT Fred E. Harrison Address Woodbine, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardiac Failure 794X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) General debility of old age DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from Jan 24, 1958 to Jan 25, 1958 that I last saw the deceased alive on Jan 24, 1958 and that death occurred at 3:57 P.M. from the causes and on the date stated above.	
ACTUAL SIGNATURE C. M. Van Poole M.D.		ADDRESS (Street, city or town, State) Mt. Airy Md DATE SIGNED 1-25-58	
PHYSICIAN'S NAME (Type) C. M. Van Poole			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 1-28-1958	22c. NAME OF CEMETERY OR CREMATORY Prospect	22d. LOCATION (City, town, or county) (State) Frederick Co., Md.
23. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz, ADDRESS Winfield, Md.		24a. REC'D BY REGISTRAR JAN 28 '58	24b. REGISTRAR'S SIGNATURE Al. Search

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text]		SEX [Faint text]		AGE [Faint text]	
DATE OF DEATH [Faint text]		PLACE OF DEATH [Faint text]		TIME OF DEATH [Faint text]	
CAUSE OF DEATH [Faint text]		MANNER OF DEATH [Faint text]		PLACE OF BURIAL [Faint text]	
SIGNATURE OF DECEASED [Faint text]		SIGNATURE OF WITNESS [Faint text]		SIGNATURE OF PHYSICIAN [Faint text]	
SIGNATURE OF CLERK [Faint text]		SIGNATURE OF REGISTRAR [Faint text]		SIGNATURE OF JUDGE [Faint text]	

BUREAU K. R.

JAN 28 1939

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

512 CERTIFICATE OF DEATH

Reg. Dist. No.

00506

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN TB 29 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) Springfield State Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3701-4	
3. NAME OF DECEASED (Type or print) Eleanor Esther Elizabeth Cook Ricketts HINES		4. DATE OF DEATH Month January Day 8 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 28, 1915
9. AGE (In years last birthday) 42 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edward Cook		14. MOTHER'S MAIDEN NAME Flora Delosier	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -	
17. INFORMANT Springfield Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intestinal Obstruction 570.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. associated with convulsive disorder with psychotic reaction.			
INTERVAL BETWEEN ONSET AND DEATH Days			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from December 9, 1957 , to January 8, 1958 , that I last saw the deceased alive on January 8, 1958 , and that death occurred at 4:00 P. M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Walther H. Sonnenfeldt M.D.		ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 1/9/58	
PHYSICIAN'S NAME (Type) Walther H. Sonnenfeldt, M.D.		Sykesville, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) <input checked="" type="checkbox"/> BURIAL		22b. DATE THEREOF 1/11/58	
22c. NAME OF CEMETERY OR CREMATORY St. Anthony's		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Frank H. Newell		24a. REC'D BY REGISTRAR JAN 14 58	
24b. REGISTRAR'S SIGNATURE W. J. Search			

BUREAU V. S.

JAN 15 1953

RECEIVED

513

CERTIFICATE OF DEATH

Reg. Dist. No.

00507

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY ---			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Sykesville				c. LENGTH OF STAY IN 1b since 4-26-52			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Frank Middle Christian Last HULSEMAN				4. DATE OF DEATH Month January Day 27 Year 1958			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 12, 1882	
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months --- Days --- Hours --- Min. ---		IF UNDER 24 HRS. Months --- Days --- Hours --- Min. ---			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Guard at pier				10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? United States							
13. FATHER'S NAME Henry Hulseman				14. MOTHER'S MAIDEN NAME Louise Heatinraw			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. unknown		17. INFORMANT Records of Springfield State Hospital Address Sykesville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 491x NOT DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO (c) ---							INTERVAL BETWEEN ONSET AND DEATH 5 days years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Psychosis with cerebral arteriosclerosis, with hemiplegia							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) ---				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ---			
20c. TIME OF INJURY Month, Day, Year Hour a. m. --- p. m. --- 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ---	
20f. (City or town) ---				20g. (County) ---		20h. (State) ---	
21. I certify that I attended the deceased from April , 19 52 , to January 27 , 19 58 , that I last saw the deceased alive on January 26 , 19 58 , and that death occurred at 3:00 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 1/27/58							
ACTUAL SIGNATURE Agustin del Campo				M.D. Springfield State Hospital			
PHYSICIAN'S NAME (Type) Agustin del Campo				Sykesville, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan 30, 1958		22c. NAME OF CEMETERY OR CREMATORY Oak Lawn		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Lilly & Zeiler Inc., 403 S. Wolfe Street				24a. REC'D BY REGISTRAR DATE JAN 29 1958		24b. REGISTRAR'S SIGNATURE ---	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers, page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

BUREAU V. 2

JAN 29 1938

RECEIVED

514

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Manchester		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Manchester	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Manchester, Md. R. D. 1 (Manchester Dist.)		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Flora Middle V. Last Humbert		4. DATE OF DEATH Month January Day 9 Year 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1874 December, 29 -
9. AGE (In years last birthday) 83 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife-Housework		12. KIND OF BUSINESS OR INDUSTRY Own home	
13. BIRTHPLACE (State or foreign country) Carroll Co., Md.		14. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. FATHER'S NAME Wertin Frock		16. MOTHER'S MAIDEN NAME Rebecca Leister	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		18. SOCIAL SECURITY NO. No.	
19. INFORMANT Mrs. George U. Sullivan, Manchester, Md. R.D.1		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 592x DUE TO Myocardial Infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic Nephritis - Arteriosclerosis (c) Chronic Nephritis - Arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH 20 Yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 19.30 , 19 58 , to Jan 9 , 19 58 , that I last saw the deceased alive on Dec 27 , 19 57 , and that death occurred at 10:30 a.m. , from the causes and on the date stated above. (at office) ADDRESS (Street, city or town, state) Littlestown, Adams Co., Pa. DATE SIGNED Jan 9 1958			
ACTUAL SIGNATURE George P. Ard		M.D. George P. Ard	
PHYSICIAN'S NAME (Type) George P. Ard		ADDRESS 139 Carlisle St. Harrisburg, Pa.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/11/58	
22c. NAME OF CEMETERY OR CREMATORY Mt. Carmel Cemetery		22d. LOCATION (City, town, or county) (State) Littlestown, Adams Co., Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE Richard A. Little		ADDRESS Littlestown, Pa.	
24a. REC'D BY REGISTRAR DATE JAN 10 1958		24b. REGISTRAR'S SIGNATURE W. H. Leach	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

515

CERTIFICATE OF DEATH

Reg. Dist. No.

00509

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 8 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mary Middle Martha Last Insley		4. DATE OF DEATH Month 1 Day 11 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-11-74
9. AGE (In years last birthday) 83 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Alexander Redmon		14. MOTHER'S MAIDEN NAME Martha Norris	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. unkn	
17. INFORMANT Springf. State Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gangrene of right lower leg DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Thrombosis DUE TO (c) Arteriosclerotic cardiovascular disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chr. Brain Syndr. assoc. with Cerebr. Arteriosclerosis			
INTERVAL BETWEEN ONSET AND DEATH days days years			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-3- , 19 58 , to 1-11- , 19 58 , that I last saw the deceased alive on 1-11- , 19 58 , and that death occurred at 8:00 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Edmund Lusthaus M.D. Springfield State Hospital 1-12-58 ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) Edmund Lusthaus M.D. Sykesville, Maryland.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 14, 1958	
22c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc.		ADDRESS 1217 St. Paul Street	
24a. REC'D BY REGISTRAR DATE JAN 14 '58		24b. REGISTRAR'S SIGNATURE W. H. Smith	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

516 CERTIFICATE OF DEATH

00510

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural --Mt. Airy	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pullen Nursing Home		d. STREET ADDRESS Poplar Springs	
3. NAME OF DECEASED (Type or print) First LAURA Middle KELLEY Last KELLEY		4. DATE OF DEATH Month Jan Day 5 Year 1958	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-17-1882
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months 7 Days 13 Hours 2 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY ---	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Jeremiah Kelley		14. MOTHER'S MAIDEN NAME Margaret Burall	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. ----	
17. INFORMANT Mrs. Elva Pickeft		Address Mt. Airy, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest, coronary thrombosis, 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerosis generalized, dehydrated mother, DUE TO (c) Cerebral degeneration.			INTERVAL BETWEEN ONSET AND DEATH 1954 1958
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 260x			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1954 , to Jan 5 , 19 58 , that I last saw the deceased alive on 5 Jan , 19 58 , and that death occurred at 4:45 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Howard E. Hall		ADDRESS (Street, city or town, state) Sykesville, Md. DATE SIGNED 5 Jan 58	
PHYSICIAN'S NAME (Type) HOWARD E. HALL			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 1-8-1958	22c. NAME OF CEMETERY OR CREMATORY Poplar Springs	22d. LOCATION (City, town, or county) (State) Howard Co., Maryland
23. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz,		ADDRESS Winfield, Maryland	
24a. REC'D BY REGISTRAR DATE JAN 8 '58		24b. REGISTRAR'S SIGNATURE W. H. Beach	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 could be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

517

CERTIFICATE OF DEATH

00511

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. City ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 2yrs. 9mos. 20days Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		d. STREET ADDRESS 502 W. 37th St., Zone 11	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Dorothy Emma Enlet KRAUSSE		4. DATE OF DEATH Month Day Year January 10, 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 27, 1902
9. AGE (In years last birthday) yrs. 55		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jacob Enlet		14. MOTHER'S MAIDEN NAME Emma Kauh	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. -	
17. INFORMANT Springfield Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) C.B.S. associated with diseases of unknown or uncertain cause; Huntington's chorea, with psychotic reaction. (b) (c) INTERVAL BETWEEN ONSET AND DEATH Days			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 20, 1955 , to January 10, 1958 , that I last saw the deceased alive on January 10, 1958 , and that death occurred at 8:45 A. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Walther H. Sonnenfeldt		ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 1/10/58	
PHYSICIAN'S NAME (Type) Walther H. Sonnenfeldt, M.D.		Sykesville, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 14-1958	
22c. NAME OF CEMETERY OR CREMATORY Woodlawn		22d. LOCATION (City, town, or county) (State) Baltimore Co. Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Burgee Funeral Home Norace H. Burgee		24a. REC'D BY REGISTRAR DATE JAN 13 '58	
24b. REGISTRAR'S SIGNATURE W. L. ...			

RECEIVED

518

CERTIFICATE OF DEATH

00512

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE Maryland b. COUNTY Garrett			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 6yrs. 2mos. 20days			
d. NAME OF HOSPITAL (If not in hospital, give street address) Springfield State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Elizabeth Middle MORGAN Last MORGAN				4. DATE OF DEATH Month January Day 26 Year 1958			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Unknown	9. AGE (In years last birthday) 75 ? yrs.	IF UNDER 1 YEAR Months 75 Days ? Hours ? Min. ?	IF UNDER 24 HRS. Months 75 Days ? Hours ? Min. ?	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Clinton Morgan				14. MOTHER'S MAIDEN NAME Marcy E. Saunders			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) -		16. SOCIAL SECURITY NO. -		17. INFORMANT Springfield State Hospital			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive arteriosclerotic cardiovascular disease 443x DUE TO disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) - DUE TO (c) -						INTERVAL BETWEEN ONSET AND DEATH Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Psychosis with cerebral arteriosclerosis.						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)					
20c. TIME OF INJURY Hour 19 a. m. 19 p. m.	Month 19	Day 19	Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Springfield State Hospital	(County) - (State) -
21. I certify that I attended the deceased from March 7, 1955 to January 26, 1958 , that I last saw the deceased alive on January 26, 1958 , and that death occurred at 6:30 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Agustin del Campo M.D.				ADDRESS (Street, city or town, state) Springfield State Hospital			
PHYSICIAN'S NAME (Type) Agustin del Campo, MD				DATE SIGNED 1/27/58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/29/1958		22c. NAME OF CEMETERY OR CREMATORY Pleasant Valley Cem.		22d. LOCATION (City, town, or county) (State) near Mt. Lake Park, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Leighton General Home, Oakland, Md.				24a. REC'D BY REGISTRAR DATE 1/27/58		24b. REGISTRAR'S SIGNATURE Q. L. Beach	

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MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

CERTIFICATE OF DEATH

1. NAME OF DECEASED [REDACTED]		2. SEX [REDACTED]		3. AGE [REDACTED]	
4. DATE OF DEATH [REDACTED]		5. TIME OF DEATH [REDACTED]		6. PLACE OF DEATH [REDACTED]	
7. CAUSE OF DEATH [REDACTED]		8. MANNER OF DEATH [REDACTED]		9. MEDICAL HISTORY [REDACTED]	
10. HISTORY OF PRESENT ILLNESS [REDACTED]		11. PHYSICAL EXAMINATION [REDACTED]		12. LABORATORY EXAMINATIONS [REDACTED]	
13. TREATMENT [REDACTED]		14. POST-MORTEM EXAMINATION [REDACTED]		15. SIGNATURE OF PHYSICIAN [REDACTED]	
16. SIGNATURE OF REGISTRAR [REDACTED]		17. SIGNATURE OF CLERK [REDACTED]		18. SIGNATURE OF JURY [REDACTED]	

BUREAU V. 8

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

519

CERTIFICATE OF DEATH

00513

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Taneytown				c. LENGTH OF STAY IN 1b 3 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Clara Middle Florida Last Peters				4. DATE OF DEATH Month January Day 18 Year 1958			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 22, 1921	
9. AGE (In years lost birthday) 36 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Hagerstown, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME William O. Peters				14. MOTHER'S MAIDEN NAME Eleanor Ovelman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214-14-6373		17. INFORMANT Lawrence G. Peters Address Taneytown, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer of Brain (Glioblastoma) 1930 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 260X Diabetes Mellitus							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 8/24	
20f. (City or town) 174				20g. (County) (State)			
21. I certify that I attended the deceased from 1/18/58 , 19 58 , to 1/18 , 19 58 , that I last saw the deceased alive on 1/14 , 19 58 , and that death occurred at 7:55 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE R. S. McVaugh				ADDRESS (Street, city or town, state) 497 Madison St. Taneytown, Md.			
PHYSICIAN'S NAME (Type) R. S. McVaugh				DATE SIGNED 1/18/58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/21/1958		22c. NAME OF CEMETERY OR CREMATORY Keysville Cemetery		22d. LOCATION (City, town, or county) (State) Keysville, Carroll Co. Md.	
23. BURIAL DIRECTOR'S SIGNATURE S. L. Allison				ADDRESS Emmitsburg, Md.		24a. REC'D BY REGISTRAR JAN 21 '58	
				24b. REGISTRAR'S SIGNATURE Alberich			

CERTIFICATE OF DEATH

1. NAME OF DECEASED Carroll		2. SEX Male	
3. AGE 40		4. DATE OF BIRTH 1918	
5. PLACE OF BIRTH St. Louis, Mo.		6. OCCUPATION None	
7. MARITAL STATUS Married		8. DATE OF MARRIAGE 1940	
9. NAME OF SPOUSE Carroll		10. DATE OF DEATH 1958	
11. PLACE OF DEATH Home		12. CAUSE OF DEATH Heart Disease	
13. MEDICAL HISTORY None		14. SIGNATURE OF PHYSICIAN [Signature]	
15. SIGNATURE OF REGISTRAR [Signature]		16. OFFICIAL SEAL [Seal]	

RECEIVED
JAN 21 1958
BUREAU V. 3

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

520

CERTIFICATE OF DEATH

Reg. Dist. No.

00514

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City 311	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 7 months 20 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3101.4	
3. NAME OF DECEASED (Type or print) First Middle Last Charles Frederick Pfeitz		4. DATE OF DEATH Month Day Year 1 1 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-27-75
9. AGE (In years last birthday) yrs. 82		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Gus Davis		14. MOTHER'S MAIDEN NAME Mary E. Price	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 760-88-211	
17. INFORMANT Hospital records.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 491X not DUE TO Arteriosclerotic Heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arteriosclerosis (c) Generalized Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH days years years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. Chronic brain syndrome associated with circulatory disturbances, with cerebral arteriosclerosis with psychotic reaction. Infected bed sore.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5-10- , 19 57 , to 1-1- , 19 58 , that I last saw the deceased alive on 1-1- , 19 58 , and that death occurred at 2.10 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Agustin del Campo		ADDRESS (Street, city or town, state) Springfield State Hospital.	
PHYSICIAN'S NAME (Type) Agustin del Campo. M.D.		DATE SIGNED 1-1-58	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF JAN 4, 1958	
22c. NAME OF CEMETERY OR CREMATORY IVY HILL		22d. LOCATION (City, town, or county) (State) LAUREL, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Austin B. Donovan		24a. REC'D BY REGISTRAR 6 1958	
ADDRESS 3818 Roland Ave.		24b. REGISTRAR'S SIGNATURE A. W. Hedrick	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

521

CERTIFICATE OF DEATH

00515

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville c. LENGTH OF STAY IN b 17yrs10mths7dys d. NAME OF HOSPITAL (If not in hospital, give street address) Springfield State Hospital.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 2910 Reisterstown Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Martha Middle Phillips Last Phillips		4. DATE OF DEATH Month Jan Day 19 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan 12-1891.
9. AGE (In years last birthday) 67		IF UNDER 1 YEAR Months 67 Days 19 Hours 19 Min. 58	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY HOME	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Wicox		14. MOTHER'S MAIDEN NAME Mary Jaeger	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Unknown		16. SOCIAL SECURITY NO. unk	
17. INFORMANT Hospital records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of the head of the pancreas 157X 100 TO with metastases in the liver and peritoneum Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. not (b) DUE TO Arteriosclerotic heart disease years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Manic depressive psychosis. Manic type- Chronic Nephrosclerosis			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. g. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 8 , 19 58 , to Jan. 19 , 19 58 , that I last saw the deceased alive on Jan. 19- , 19 58 , and that death occurred at 7.30A. M., from the causes and on the date stated above.			
ACTUAL SIGNATURE Agustin del Campo		ADDRESS (Street, city or town, state) Springfield State Hospital.	
PHYSICIAN'S NAME (Type) Agustin del Campo M.D.		DATE SIGNED Jan 19-58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-22-58	
22c. NAME OF CEMETERY OR CREMATORY Springfield		22d. LOCATION (City, town, or county) (State) Sykesville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Arthur H. Haight		ADDRESS Sykesville, Md.	
24a. REC'D BY REGISTRAR Jan 27 '58		24b. REGISTRAR'S SIGNATURE W. L. Leach	

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES H. HARRIS		Male		65		Jan 15 1873		Baltimore		Maryland		United States			
MARRIAGE		SINGLE		MARRIED		DIVORCED		WIDOWED		RE-MARRIED		OTHER			
DATE OF MARRIAGE		JAN 15 1895		JAN 15 1895		JAN 15 1895		JAN 15 1895		JAN 15 1895		JAN 15 1895			
DATE OF DEATH		JAN 15 1938		JAN 15 1938		JAN 15 1938		JAN 15 1938		JAN 15 1938		JAN 15 1938			
PLACE OF DEATH		Baltimore		Baltimore		Baltimore		Baltimore		Baltimore		Baltimore			
CITY		Baltimore		Baltimore		Baltimore		Baltimore		Baltimore		Baltimore			
STATE		Maryland		Maryland		Maryland		Maryland		Maryland		Maryland			
COUNTRY		United States		United States		United States		United States		United States		United States			
CAUSE OF DEATH		Heart Disease		Heart Disease		Heart Disease		Heart Disease		Heart Disease		Heart Disease			
MANNER OF DEATH		Natural		Natural		Natural		Natural		Natural		Natural			
DATE OF REPORT		JAN 15 1938		JAN 15 1938		JAN 15 1938		JAN 15 1938		JAN 15 1938		JAN 15 1938			
REPORTED BY		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS			
SIGNATURE		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS			
DATE		JAN 15 1938		JAN 15 1938		JAN 15 1938		JAN 15 1938		JAN 15 1938		JAN 15 1938			

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JAN 27 1938

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

522

CERTIFICATE OF DEATH

00516

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Balto. City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 1 mo. 8 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
3. NAME OF DECEASED (Type or print) First Alexander Middle POLKOWSKI Last		4. DATE OF DEATH Month January Day 5 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 15, 1875
9. AGE (In years and birthdays) 82 yrs.		IF UNDER 1 YEAR Months 5 Days 1 Hours 4 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Poland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. -	
17. INFORMANT Springfield Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease. 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. associated with cerebral arteriosclerosis, with psychotic reaction.			
INTERVAL BETWEEN ONSET AND DEATH Years			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from November 27, 1957 , to January 5, 1958 , that I last saw the deceased alive on January 5, 1958 , and that death occurred at 8:00 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Walther H. Sonnenfeldt		ADDRESS (Street, city or town, state) Springfield State Hospital	
PHYSICIAN'S NAME (Type) Walther H. Sonnenfeldt, M.D.		DATE SIGNED 1/6/58	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR	
24b. REGISTRAR'S SIGNATURE		DATE	

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

523

CERTIFICATE OF DEATH

00517

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>CARROLL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NEW WINDSOR</u>		c. LENGTH OF STAY IN 1b <u>3 MONTHS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NEW WINDSOR</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>LAMBERT AVE</u>				d. STREET ADDRESS <u>LAMBERT AVE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>STERLING NORMAN POOLE SR</u>				4. DATE OF DEATH Month Day Year <u>JAN 31 1958</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/22/1897</u>	9. AGE (In years last birthday) <u>60</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN FARM</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>WILLIAM S POOLE</u>				14. MOTHER'S MAIDEN NAME <u>HALLIE ANGEL</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u>		16. SOCIAL SECURITY NO. <u>213-36-8714</u>		17. INFORMANT Address <u>RUTH F POOLE, NEW WINDSOR MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> <u>153.9</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Original site - Bowel</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>Jan. 20, 1956</u> , to <u>11/31/58</u> , 19____, that I last saw the deceased alive on <u>11/31/58</u> , 19____, and that death occurred at <u>4:30 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>M. E. Robertson</u>				ADDRESS (Street, city or town, state) <u>New Windsor Md</u>		DATE SIGNED <u>11/31/58</u>	
PHYSICIAN'S NAME (Type) <u>M E ROBERTSON</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2/3/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>LINGANORE</u>		22d. LOCATION (City, town, or county) (State) <u>UNIONVILLE MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>DD HARTZLER & SONS</u>				ADDRESS <u>NEW WINDSOR MD</u>		24a. REC'D BY REGISTRAR <u>Feb 4 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. H. H. H.</u>			

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00518

524

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Finksburg	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pullen Nursing Home		d. STREET ADDRESS Westminster Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Emmett Middle Bingham Last Prugh		4. DATE OF DEATH Month Jan. Day 31 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 14, 1882
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Upton Prugh		14. MOTHER'S MAIDEN NAME Mary Jane Bingham	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Francis Crawford, Westminster, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Decompensation 527.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of Prostate DUE TO (c) Emphysema		INTERVAL BETWEEN ONSET AND DEATH 2 yrs 9 mo. 7 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Falx fractured ribs & injured left hip & lumbar spine		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) Patient fell off of building		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 10 p. m. 7 19 58		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Westminster Pike		20f. (City or town) (County) (State) Reisterstown Balto. Md.	
21. I certify that I attended the deceased from 6-2 , 19 57 , to Jan 31 , 19 58 , that I last saw the deceased alive on Jan 30 , 19 58 , and that death occurred at 8 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6 Hanover Rd. DATE SIGNED 2-1-58			
ACTUAL SIGNATURE D. D. Caples		M.D. 6 Hanover Rd.	
PHYSICIAN'S NAME (Type) D. D. CAPLES		Reisterstown, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 2, 1958	
22c. NAME OF CEMETERY OR CREMATORY Providence Cemetery		22d. LOCATION (City, town, or county) (State) Gamber, Carroll County, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. F. Eline & Sons, Reisterstown, Md.		24a. REC'D BY REGISTRAR DATE FEB 4 58	
		24b. REGISTRAR'S SIGNATURE W. J. Seach	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

DATE OF DEATH

PLACE OF DEATH

DATE OF BIRTH

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FEB 4 1938

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THE STATE OF MARYLAND

DEPARTMENT OF HEALTH

BALTIMORE, MARYLAND

FEB 4 1938

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

473
CERTIFICATE OF DEATH

Reg. Dist. No.

00520

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>		c. LENGTH OF STAY IN 1b <u>7 YEARS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>COURT PLACE</u>		e. STREET ADDRESS <u>1 COURT PLACE</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>WILFORD FRANKLIN RAILING</u>		4. DATE OF DEATH Month Day Year <u>JANUARY 16 1958</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT 24, 1885</u>
9. AGE (In years last birthday) <u>72</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>GAS AND ELECTRIC CO.</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>ENGINEER</u>	
11c. BIRTHPLACE (State or foreign country) <u>FREDERICK, MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>CHRISTIAN RAILING</u>		14. MOTHER'S MAIDEN NAME <u>MARGARET MEARLING</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>212-05-6604</u>	
17. INFORMANT <u>MRS. MARY CRAIG RAILING, WESTMINSTER MD</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u> 744.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>MYASTHENIA GRAVIS</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>24 HOURS</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>JAN. 16, 1958</u> , to <u>JAN. 16, 1958</u> , that I last saw the deceased alive on <u>JAN. 16, 1958</u> , and that death occurred at <u>1:45 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Daniel I. Welliver</u>		M.D. <u>CHURCH ST. WESTMINSTER, MD 1/16/58</u>	
PHYSICIAN'S NAME (Type) <u>DANIEL I. WELLIVER, WESTMINSTER, MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/18/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Westminster Cemetery, Westminster, Md</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Myers, Jr. Westminster, Md</u>		ADDRESS	
24a. REC'D BY REGISTRAR DATE <u>JAN 21 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Rebecca</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

526 CERTIFICATE OF DEATH

00521

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>			c. LENGTH OF STAY IN 1b <u>7mo, 5dy</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville (rural) near Gist</u>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hospital</u>				d. STREET ADDRESS <u>Route 3, Box 234</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Lottie</u> Middle <u>Geneva</u> Last <u>Randel</u>				4. DATE OF DEATH Month <u>January</u> Day <u>22</u> Year <u>1958</u>					
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>December 11, 1881</u>		9. AGE (In years last birthday) <u>74</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joshua Barnes</u>				14. MOTHER'S MAIDEN NAME <u>Georgeanna --</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, name or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>Springfield Hospital records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-respiratory insufficiency</u> DUE TO <u>Pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u> </u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CBS associated with circulatory disturbance, with cerebral arterio-sclerosis, with psychotic reaction</u>								INTERVAL BETWEEN ONSET AND DEATH <u>hours</u> <u>day</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o. m. <u>19</u> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from <u>June 17, 1957</u> to <u>January 22, 1958</u> , that I last saw the deceased alive on <u>January 22, 1958</u> , and that death occurred at <u>11:45A</u> M, from the causes and on the date stated above.									
ADDRESS (Street, city or town, state) <u>Springfield State Hospital, Sykesville Md.</u> DATE SIGNED <u>1/22/58</u>									
ACTUAL SIGNATURE <u>Gertie Stuenkel</u>									
PHYSICIAN'S NAME (Type) <u>DR. Gertie Stuenkel Springfield State Hospital, Sykesville Md.</u>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-25-1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>ELLSWORTH ARMACOST</u>				ADDRESS <u>4600 Liberty Heights</u>					
24a. REC'D BY REGISTRAR <u>24 '58</u>				24b. REGISTRAR'S SIGNATURE <u>Ellsworth</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
MARRIAGE		MARRIED		SINGLE		WIDOW		DIVORCED		SEPARATED		OTHER			
OCCUPATION		PROFESSION		INDUSTRY		BUSINESS		ART		SCIENCE		LITERATURE		OTHER	
EDUCATION		SCHOOL		COLLEGE		UNIVERSITY		POSTGRADUATE		OTHER					
RELIGION		METHODIST		BAPTIST		CATHOLIC		LUTHERAN		PRESBYTERIAN		OTHER			
CAUSE OF DEATH		DISEASE		INJURY		POISON		OTHER							
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY					
SIGNATURE OF PHYSICIAN		SIGNATURE OF MINISTER		SIGNATURE OF CORONER		SIGNATURE OF JURY		SIGNATURE OF DECEASED		SIGNATURE OF WITNESSES		SIGNATURE OF REGISTRAR		SIGNATURE OF CLERK	

BUREAU V. B.

JAN 24 1938

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00522

Reg. Dist. No.

527

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL TANEYTOWN</u>		c. LENGTH OF STAY IN <u>YEARS</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>RICHARD</u> First <u>ISAIAH REIFSNIDER</u> Middle Last		4. DATE OF DEATH <u>JAN</u> Month <u>11</u> Day <u>19</u> Year <u>58</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 7 - 1924</u>
9. AGE (In years last birthday) <u>33</u> yrs.		IF UNDER 1 YEAR	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>TENANT</u>	11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>ISAIAH REIFSNIDER</u>	
14. MOTHER'S MAIDEN NAME <u>ALICE RINEHART</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u>	
16. SOCIAL SECURITY NO. <u>219-12-2278</u>		17. INFORMANT <u>BETTY REIFSNIDER TANEYTOWN MD</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARBON MONOXIDE POISONING</u> <u>977.3</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>977.3</u> DUE TO (c) <u>977.3</u> DUE TO cause lost.			INTERVAL BETWEEN ONSET AND DEATH <u>5 min</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>977.3</u> DUE TO			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>1/11</u> 19 <u>58</u> p. m.	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>farm</u>	20f. (City or town) (County) (State) <u>Taneytown Carroll Md</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input checked="" type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>James T. Marsh</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JAMES T. MARSH</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>1/11/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>1/14/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>REFORMED</u>	22d. LOCATION (City, town, or county) (State) <u>TANEYTOWN MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Dr. Hartzler & Sons, Union Bridge, Md</u>		24a. REC'D BY REGISTRAR <u>DATE JAN 15 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>W. Leach</u>			

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NO. 12345
DEPT. OF HEALTH

DATE

TIME

PLACE

CAUSE

MANNER

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

Marital Status

Previous Illnesses

Drugs Taken

Alcohol Consumed

Smoking Habits

Family History

Signatures

Witnesses

Remarks

Signature of Medical Examiner

Signature of Coroner

Signature of Registrar

Signature of Burial Officer

Signature of Undertaker

Signature of Funeral Home

Signature of Cemetery

Signature of Church

Signature of Minister

Signature of Priest

Signature of Rabbi

Signature of Imam

Signature of Other

Signature of Other

Signature of Other

Signature of Other

Signature of Other

Signature of Other

Signature of Other

Signature of Other

Signature of Other

Signature of Other

Signature of Other

Signature of Other

BUREAU V. S.

JAN 15 1958

RECEIVED

528

CERTIFICATE OF DEATH

00523

Reg. Dist. No. *4*

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City 12 <i>3V01.4</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		d. STREET ADDRESS 1501 Pentridge Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Annie Middle Elizabeth Last Renshaw		4. DATE OF DEATH January 1 19 58	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 11, 1873
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Henry		14. MOTHER'S MAIDEN NAME (Elizabeth) Osborne, Emma	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Yuk	
17. INFORMANT Springfield Hospital records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c) Years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic brain syndrome associated with circulatory disturbance, with cerebral arteriosclerosis, with psychotic reaction 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from September 20, 1957 , to January 1, 1958 , that I last saw the deceased alive on January 1, 1958 , and that death occurred at 7:50 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1501 Pentridge Road, Springfield, Md. DATE SIGNED BERTRUD SONNENFELDT M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			
22b. DATE THEREOF 1/4/58		22c. NAME OF CEMETERY OR CREMATORY St. John E. U.B. Cem.	
22d. LOCATION (City, town, or county) Paradise, Pennsylvania		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck		ADDRESS 5305 Harford Road #14	
24a. REC'D BY REGISTRAR 1-2-58		24b. REGISTRAR'S SIGNATURE A. H. [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

Form No. 10

NAME OF DECEASED (Print name in full)		SEX (Male or Female)	
DATE OF BIRTH (Month, day, year)		PLACE OF BIRTH (City, State, Country)	
DATE OF DEATH (Month, day, year)		PLACE OF DEATH (City, State, Country)	
TIME OF DEATH (Hour, minute)		CAUSE OF DEATH (List all causes, beginning with immediate cause)	
MANNER OF DEATH (Natural, Accidental, Suicide, Homicide, Undetermined)		MEDICAL HISTORY (List all diseases, injuries, operations, etc.)	
OCCASION OF DEATH (List all events leading up to death)		SIGNATURE OF PHYSICIAN (Print name and title)	
SIGNATURE OF REGISTRAR (Print name and title)		SIGNATURE OF WITNESS (Print name and title)	

BUREAU V. S.

JAN 6 1938

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00524

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH

a. COUNTY

CARROLL

MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

MD.

b. COUNTY

CARROLL

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

RURAL WESTMINSTER 7 mo.

c. LENGTH OF STAY IN 1b

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

RURAL WESTMINSTER X

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

R.D. 4

d. STREET ADDRESS

RD 4

e. IS RESIDENCE
ON A FARM?YES ☐ NO ☒3. NAME OF
DECEASED
(Type or print)

BRIAN

First

Middle

Last

DARYL RICHARDS

4. DATE
OF
DEATH

Month

Day

Year

Jan 23 1958

5. SEX

M

6. COLOR OR RACE

W

7. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

JUNE 18, 1957

9. AGE (In years
last birthday)

7 yrs.

10. IF UNDER 1 YEAR IF UNDER 24 HRS.

Months Days Hours Min.

7 5

10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

PA.

12. CITIZEN OF WHAT COUNTRY?

U S A

13. FATHER'S NAME

DOUGLAS RICHARDS

14. MOTHER'S MAIDEN NAME

ANNA MAE McGINNET

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)

-

16. SOCIAL SECURITY NO.

-

17. INFORMANT

Address R.D. 4

DOUGLAS S. RICHARDS WESTMINSTER, MD.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

493X

DUE TO

PNEUMONIA

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

INTERVAL BETWEEN
ONSET AND DEATH

DAY

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY
PERFORMED?YES ☐ NO ☒20a. EXTERNAL CAUSE WAS
PRIMARY ☐ or CONTRIBUTING ☐
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY

Month, Day, Year

Hour
a. m.
p. m.

19

20d. INJURY OCCURRED

While
at work ☐ Not while
at work ☐20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held on Autopsy ☐ Inspection ☒ Inquiry ☒ and in my
opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE

James J. Marsh

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☐DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED

1/23/58

EXAMINER'S
NAME (Type)

JAMES T. MARSH

22a. BURIAL, CREMATION,
REMOVAL (Specify)

BURIAL

22b. DATE THEREOF

1-26-1958

22c. NAME OF CEMETERY OR CREMATORY

MEADOW BRANCH CEM.

22d. LOCATION (City, town, or county)

WESTMINSTER MD.

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

David C. Bankard Westminster, Md.

24a. REC'D BY REGISTRAR

DATE JAN 27 '58

24b. REGISTRAR'S SIGNATURE

A. L. Smith

RECEIVED

JAN 27 1958

BUREAU V. 5.

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED: [illegible]
2. SEX: [illegible]
3. AGE: [illegible]
4. RACE: [illegible]
5. DATE OF BIRTH: [illegible]
6. PLACE OF BIRTH: [illegible]
7. OCCUPATION: [illegible]
8. CAUSE OF DEATH: [illegible]
9. MANNER OF DEATH: [illegible]
10. SIGNATURE OF EXAMINER: [illegible]
11. DATE OF EXAMINATION: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

1

INSTRUCTIONS

TO AWARDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be completed within 24 hours after death. The information copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

530 CERTIFICATE OF DEATH

00525

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>CARROLL</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>Carroll</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>HAMPSTEAD</u>		<u>Life</u>		TOWN <u>HAMPSTEAD</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Brodbecks Rd</u>				STREET ADDRESS (If rural give location) <u>Brodbecks Rd</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Geatha Elizabeth</u> (Middle) <u>Ruby</u> (Last)				(Month) (Day) (Year) <u>JANUARY 29 1958</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>February 5 1872</u>	9. AGE last birthday <u>85</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (State or foreign country) <u>Mayland</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>LESSE Leister</u>				14. MOTHER'S MAIDEN NAME <u>SALLIE TRINE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>RAY E. Ruby HAMPSTEAD Md</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
422.1 IMMEDIATE CAUSE (A) <u>Chronic Myocarditis</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arterio-sclerotic Cardio-Vascular Disease</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> M. at work <input type="checkbox"/> at work <input type="checkbox"/>		21i. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>DEC 10</u> , 19 <u>57</u> , to <u>JAN 29</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>JAN 27</u> , 19 <u>58</u> , and that death occurred at <u>4A</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Joseph E. Bush</u> M.D.				ADDRESS (Street, city, town, state) <u>Hampstead Md</u> DATE SIGNED <u>1/29/58</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>2-1-58</u>		NAME OF CEMETERY OR CREMATORY <u>Leisters</u>		LOCATION (City, town, or county) (State) <u>Carroll Co Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>W. Leister</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Edw E Tipton</u>		ADDRESS <u>Hampstead Md</u>	
DATE <u>JAN 31 '58</u>							

CERTIFICATE OF DEATH

Form 10-1-58

1. NAME OF DECEASED: _____

2. SEX: _____ 3. AGE: _____ 4. DATE OF BIRTH: _____

5. PLACE OF BIRTH: _____ 6. OCCUPATION: _____

7. MARITAL STATUS: _____ 8. EDUCATION: _____

9. PRESENT ADDRESS: _____

10. DATE OF DEATH: _____ 11. TIME OF DEATH: _____

12. CAUSE OF DEATH: _____

13. PLACE OF DEATH: _____

14. SIGNATURE OF DECEASED: _____

15. SIGNATURE OF WITNESS: _____

16. SIGNATURE OF PHYSICIAN: _____

17. SIGNATURE OF CORONER: _____

18. SIGNATURE OF JUDGE: _____

19. SIGNATURE OF CLERK: _____

20. SIGNATURE OF REGISTRAR: _____

21. SIGNATURE OF ARCHIVIST: _____

22. SIGNATURE OF ASSISTANT: _____

23. SIGNATURE OF CLERK: _____

BUREAU V. 3

JAN 31 1958

RECEIVED

531

CERTIFICATE OF DEATH

00526

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 9 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) Springfield State Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 6	
f. STREET ADDRESS 5914 Meadow Road		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First George Middle John Last SCHREIBER		4. DATE OF DEATH Month January Day 6 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/25/13
9. AGE (In years last birthday) 44 yrs.		10. IF UNDER 1 YEAR Months 4 Days 1 Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hospital orderly		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Christian Schreiber		14. MOTHER'S MAIDEN NAME Agnes Chapman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 216-18-9580	
17. INFORMANT Springfield Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Nodular cirrhosis of the liver. 581.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Chronic alcoholism. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 yr. Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from December 27, 1957 to January 6, 1958 , that I last saw the deceased alive on January 5, 1958 , and that death occurred at 3:35 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Walther H. Sonnenfeldt		ADDRESS (Street, city or town, state) Springfield Hospital DATE SIGNED 1/6/58	
PHYSICIAN'S NAME (Type) Walther H. Sonnenfeldt, M.D.		Sykesville, Maryland.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Jan. 9, 1958	22c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery	22d. LOCATION (City, town, or county) (State) Baltimore Co. Md.
23. FUNERAL DIRECTOR'S SIGNATURE HENRY SANDER & SONS, INC.		ADDRESS Baltimore Md.	
24a. REC'D BY REGISTRAR DATE JAN 8 1958		24b. REGISTRAR'S SIGNATURE W. J. Smith	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

532

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural. Martinsburg</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural. Martinsburg</u>	
c. LENGTH OF STAY IN 1b <u>10 years</u>		d. STREET ADDRESS <u>Tringle road</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Roland</u> Middle <u>O</u> Last <u>Sheppard</u>		4. DATE OF DEATH Month <u>Jan</u> Day <u>23</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 13, 1886</u>
9. AGE (in years last birthday) <u>71</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Agriculture</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John Sheppard</u>		14. MOTHER'S MAIDEN NAME <u>Mary Smith</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-18-0011A</u>	
17. INFORMANT <u>Mrs Elizabeth Sheppard - Sykesville, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest, arteriosclerosis, atherosclerosis</u> <u>433.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>fibrosclerosis, bronchial pneumonia</u> DUE TO (c) <u>coronary thrombosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1956 TO 1958</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1956</u> , 19 <u>23 Jan</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>23 Jan</u> , 19 <u>58</u> , and that death occurred at <u>4:30 A. M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Howard E. Hall</u> M.D.		ADDRESS (Street, city or town, state) <u>Sykesville, Md</u> DATE SIGNED <u>23 Jan 58</u>	
PHYSICIAN'S NAME (Type) <u>HOWARD E. HALL</u>		<u>SYKESVILLE, MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1-25-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Springfield</u>	22d. LOCATION (City, town, or county) (State) <u>Sykesville, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur H. Haight</u>		ADDRESS <u>Sykesville, Md.</u>	
24a. REC'D BY REGISTRAR <u>JAN 24 1958</u>		24b. REGISTRAR'S SIGNATURE <u>W. J. ...</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JAN 27 1953

BUREAU V. S.

WILL BOND

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

533

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 22 years 19 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) Springfield State Hospital				d. STREET ADDRESS 517 N. Market Street			
3. NAME OF DECEASED (Type or print) First William Louis Middle Simmons Last Simmons				4. DATE OF DEATH Month 1 Day 25 Year 58			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-20-1879		9. AGE (In years last birthday) yrs. 78	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) barber			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Louis Simmons			14. MOTHER'S MAIDEN NAME Mary E. Brengle				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) unkn		17. INFORMANT S.S. Hospital Records Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septic emia due to inguinal & scrotal abscess 692.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH weeks years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CNS syphilis, tabetic type, Diabetes Mellitus 025X							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 10-20- , 1954 , to 1-24- , 1958 , that I last saw the deceased alive on 1-24- , 1958 , and that death occurred at 8:15 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Edmund Lusthaus M.D.				ADDRESS (Street, city or town, state) Springfield State Hospital		DATE SIGNED 1-25-58	
PHYSICIAN'S NAME (Type) Edmund Lusthaus M.D.				Sykesville, Maryland.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-28-58		22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland				24a. REC'D BY REGISTRAR DATE JAN 28 '58		24b. REGISTRAR'S SIGNATURE Reed Smith	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
JAN 28 1959
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BUREAU V. S.

534

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY M Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 4 mos. 4 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS Rolling Acres			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Grace Middle Myrtle Last SMITH				4. DATE OF DEATH Month January Day 29 Year 19 58			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 18, 1883	
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Office worker				10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Lysander Smith				14. MOTHER'S MAIDEN NAME Amanda Mullinix			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -		17. INFORMANT Address Springfield Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia due to decubitus ulcers 053.3 DUE TO (b) Generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. associated with cerebral arteriosclerosis, with psychotic reaction.							
INTERVAL BETWEEN ONSET AND DEATH Days Years							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Sept. 25, 1957 , to January 29, 1958 , that I last saw the deceased alive on January 29, 1958 , and that death occurred at 8:00 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Edmund Lusthaus				ADDRESS (Street, city or town, state) Springfield State Hospital			
DATE SIGNED 1/30/58							
PHYSICIAN'S NAME (Type) Edmund Lusthaus, M.D.				Sykesville, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/1/58		22c. NAME OF CEMETERY OR CREMATORY Howard Chapel Cem.		22d. LOCATION (City, town, or county) (State) Howard Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Dickner				24a. REC'D BY REGISTRAR DATE FEB 3 1958		24b. REGISTRAR'S SIGNATURE W. H. ...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1958

BUREAU V. B.

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

535 Item 2 Film 0225 2-3-58 et
CERTIFICATE OF DEATH

00530

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN lb 6mos. 19 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS 4701 N. Charles St. 1200 Valley / 34.11 / Balto. / 7.			
3. NAME OF DECEASED (Type or print) First Zerline Middle Emilie Last STAUF				4. DATE OF DEATH Month January Day 16, Year 1958			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH November 27, 1863 94 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frederick Stauf				14. MOTHER'S MAIDEN NAME Christine Gerhardt			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -		17. INFORMANT Springfield Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with senile brain disease with psychotic reaction.							INTERVAL BETWEEN ONSET AND DEATH Years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from June 27, 1957 , to January 16, 1958 , that I last saw the deceased alive on January 16, 1958 , and that death occurred at 7:45P M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Edmund Lusthaus				ADDRESS (Street, city or town, state) Springfield State Hospital		DATE SIGNED 1/17/58	
PHYSICIAN'S NAME (Type) Edmund Lusthaus, M.D.				Sykesville, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 20, 1958		22c. NAME OF CEMETERY OR CREMATORY Loudon Park		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John O. Mitchell & Sons Inc. 1900 Eutaw Place				24a. REC'D BY REGISTRAR JAN 20 '58		24b. REGISTRAR'S SIGNATURE W. F. ...	

BUREAU V. S.

JAN 20 1953

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

536

CERTIFICATE OF DEATH

00531

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Frederick</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sikesville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u> 10112	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hospital</u>		d. STREET ADDRESS <u>Frederick County Home</u>	
3. NAME OF DECEASED (Type or print) First <u>Lewis</u> Middle <u>Stewart</u> Last <u>Stewart</u>		4. DATE OF DEATH Month <u>January</u> Day <u>25</u> Year <u>1958</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/19/83</u> 74 YEARS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		11. BIRTHPLACE (State or foreign country) <u>unknown</u>	
13. FATHER'S NAME <u>unknown</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>579-09-508</u>	
17. INFORMANT Address <u>Records of the Springfield Hospital</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho pneumonia</u> 420.1 DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic cardio-vascular disease</u> DUE TO (c) <u>10 years</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 hours</u> <u>12 hours</u> <u>10 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Chronic brain syndrome assoc. with cerebral arteriosclerosis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1-17</u> , 19 <u>58</u> , to <u>1-25</u> , 19 <u>58</u> that I last saw the deceased alive on <u>1-25</u> , 19 <u>58</u> , and that death occurred at <u>10:15</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Walter Knopp</u> M.D.		ADDRESS (Street, city or town, state) <u>Springfield State Hospital</u> DATE SIGNED <u>1-26-58</u>	
PHYSICIAN'S NAME (Type) <u>WALTER KNOPP</u>		<u>Sikesville, MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1/29/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Potomac Memorial Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Potomac, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Cheng Chase</u> ADDRESS <u>Funeral Home 5103 Wisconsin Ave</u>		24a. REC'D BY REGISTRAR <u>Rebecca</u> 24b. REGISTRAR'S SIGNATURE <u>Rebecca</u>	

BUREAU OF THE ARMY

JAN 31 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00532

Reg. Dist. No.

474

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>CARROLL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>		c. LENGTH OF STAY IN 1b <u>30 YRS.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>532 E. MAIN</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>WILLIAM</u> Middle <u>VICTOR</u> Last <u>STREVIK</u>		4. DATE OF DEATH Month <u>JAN</u> Day <u>27</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG. 2, 1909</u> yrs. <u>48</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>GEN. STORE & AUCTION</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MD.</u>	
11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>CHARLES V. STREVIK</u>		14. MOTHER'S MAIDEN NAME <u>DAISY L. CARR</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>186-09-1829</u>	
17. INFORMANT <u>MARY V. BAIR STREVIK</u>		Address <u>532 E. MAIN WESTMINSTER MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>James J. Marsh</u>		DATE SIGNED <u>1/27/58</u>	
EXAMINER'S NAME (Type) <u>JAMES T. MARSH</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>1-30-1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>TRIDERS REFORMED CEM.</u>	22d. LOCATION (City, town, or county) (State) <u>WESTMINSTER MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>David W. Bankard Westminster, Md.</u>		24a. REC'D BY REGISTRAR <u>Jan 31 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Alfred Smith</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT
CHIEF AND
GOV

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BURKAW V. A.

JAN 31 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2, Film G224, 1/10/58, 537

CERTIFICATE OF DEATH

Reg. Dist. No. 00533

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 2 mos. 8 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg/ Catonsville 0852.2	
4. DATE OF DEATH Month January Day 3 Year 1958		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Jennie Middle Creighton Hardy Last STUART		5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH February 1, 1872		9. AGE (In years last birthday) 85 yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George E. Hardy		14. MOTHER'S MAIDEN NAME Eliza Regester	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -	
17. INFORMANT Springfield Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. associated with senile brain disease with psychotic reaction.		INTERVAL BETWEEN ONSET AND DEATH Years Years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 25, 1957 , to January 3, 1958 , that I last saw the deceased alive on January 3, 1958 , and that death occurred at 4:35 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Edmund Lusthaus M.D. Springfield State Hospital 1/3/58		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) Edmund Lusthaus, M.D. Sykesville, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/6/58	
22c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Ticker & Sons North & Pa Ave.		24a. REC'D BY REGISTRAR DATE JAN 6 '58	
24b. REGISTRAR'S SIGNATURE Rebecca			

BUREAU V. S.

JAN 7 1958

RECEIVED

Reg. Dist. No.

538
TELECHIS

00534

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		d. STREET ADDRESS 712 Portland St	
3. NAME OF DECEASED (Type or print) Nellie		4. DATE OF DEATH January 1 1958	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 1881
9. AGE (In years last birthday) 76 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		12. CITIZEN OF WHAT COUNTRY? Lithuania	
13. FATHER'S NAME George Butkus		14. MOTHER'S MAIDEN NAME Katherine Kelint	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or known) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Mr. Pius G. Butkus	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO (b) Arteriosclerotic cardiovascular disease DUE TO (c) Diabetes mellitus, severe		INTERVAL BETWEEN ONSET AND DEATH 260X days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 491X CBS ass with cerebral Arteriosclerosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 12 , 19 51 , to Dec 31 , 19 57 , that I last saw the deceased alive on Dec 31 , 19 57 , and that death occurred at 0:30 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Elizabeth Knopf		ADDRESS (Street, city or town, state) Springfield State Hospital	
PHYSICIAN'S NAME (Type) Elizabeth Knopf		DATE Jan 3 1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 1-3-58	
22c. NAME OF CEMETERY OR CREMATORY Most Holy Redeemer		22d. LOCATION (City, town, or county) (State) Bellevue Road Md	
23. FUNERAL DIRECTOR'S SIGNATURE W. Washburn		24a. REC'D BY REGISTRAR W. Washburn	
ADDRESS 637 Wash Blvd		24b. REGISTRAR'S SIGNATURE W. Washburn	

BUREAU A. S.

3 JAN 1958

RECEIVED

Reg. Dist. No.

78

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Henryton		c. LENGTH OF STAY IN 1b 651 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Henryton State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) George Dewey Turner		4. DATE OF DEATH Month January Day 13 Year 1958	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October-?-1898
9. AGE (In years last birthday) 59 yrs.		10. IF UNDER 1 YEAR Months 59 Days 59 Hours 59 Min. 59	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		12. KIND OF BUSINESS OR INDUSTRY Maryland	
13. FATHER'S NAME Albert Turner		14. MOTHER'S MAIDEN NAME Maggie Webb	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-16-9791	
17. INFORMANT Catherine Palmer - McDaniel, Maryland		18. ADDRESS Catherine Palmer - McDaniel, Maryland	
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular Insufficiency 002 X DUE TO Arteriosclerosis Hypertension DUE TO Pulmonary Tuberculosis moderately Advanced		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 2, 1956 to January 13, 1958 , that I last saw the deceased alive on January 13, 1958 , and that death occurred at 8:00 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Henryton, Maryland DATE SIGNED	
ACTUAL SIGNATURE E. M. Maculans, M.D., Supt.		PHYSICIAN'S NAME (Type) E. M. Maculans, M. D., Supt. Henryton State Hospital, Henryton	
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried Jan 16, 1958		22b. DATE THEREOF Jan 16, 1958	
22c. NAME OF CEMETERY OR CREMATORY Calabone Cem.		22d. LOCATION (City, town, or county) (State) Calabone Md.	
23. FUNERAL DIRECTOR'S SIGNATURE St. Michael's		24a. REC'D BY REGISTRAR JAN 15 '58	
24b. REGISTRAR'S SIGNATURE St. Michael's		24c. REGISTRAR'S SIGNATURE St. Michael's	

RECEIVED
JAN 15 1968
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

00536

Reg. Dist. No.

540

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland - b. COUNTY Balto. City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 1yr. 9mos. 26days			
d. NAME OF HOSPITAL (If not in hospital, give street address) Springfield State Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
d. STREET ADDRESS 1705 N. Patterson Park Ave.				• IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Martha Middle Horstman Last VALENTINE				4. DATE OF DEATH Month January Day 8, Year 1958			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 27, 1875	
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME William Horstman				14. MOTHER'S MAIDEN NAME Elizabeth Fosler			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. -		17. INFORMANT Address Springfield Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with cerebral arteriosclerosis with psychotic reaction.							INTERVAL BETWEEN ONSET AND DEATH Years Years.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour 19 a. m. p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from March 12, 1956 , to January 8, 1958 , that I last saw the deceased alive on January 8, 1958 , and that death occurred at 10:05 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Walther H. Sonnenfeldt M.D.				ADDRESS (Street, city or town, state) Springfield State Hospital		DATE SIGNED 1/8/58	
PHYSICIAN'S NAME (Type) Walther H. Sonnenfeldt, M.D.				Sykesville, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		Jan 11 1958		Baltimore		North Ave. East	
23. FUNERAL DIRECTOR'S SIGNATURE Les E Cook				ADDRESS 1701-03 Eastern Ave		24a. REC'D BY REGISTRAR DATE JAN 10 '58	
				24b. REGISTRAR'S SIGNATURE W. H. H. H.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF DECEASED	
JAMES EARL RAY		Male		35		White		April 22, 1928		Memphis, Tennessee		April 4, 1968		Memphis, Tennessee		Shot		Suicide		James Earl Ray		James Earl Ray	
13. OCCUPATION		14. EDUCATION		15. RELIGION		16. MARITAL STATUS		17. PREVIOUS ILLNESS		18. PREVIOUS SURGERY		19. PREVIOUS TRAUMA		20. PREVIOUS DRUGS		21. PREVIOUS ALCOHOL		22. PREVIOUS TOBACCO		23. PREVIOUS OTHER		24. PREVIOUS OTHER	
Attorney		High School		Methodist		Single		None		None		None		None		None		None		None		None	
25. SIGNATURE OF WITNESS		26. SIGNATURE OF WITNESS		27. SIGNATURE OF WITNESS		28. SIGNATURE OF WITNESS		29. SIGNATURE OF WITNESS		30. SIGNATURE OF WITNESS		31. SIGNATURE OF WITNESS		32. SIGNATURE OF WITNESS		33. SIGNATURE OF WITNESS		34. SIGNATURE OF WITNESS		35. SIGNATURE OF WITNESS		36. SIGNATURE OF WITNESS	
James Earl Ray		James Earl Ray		James Earl Ray		James Earl Ray		James Earl Ray		James Earl Ray		James Earl Ray		James Earl Ray		James Earl Ray		James Earl Ray		James Earl Ray		James Earl Ray	

RECEIVED
 JAN 13 1968
 BUREAU V. S.

OFFICIAL COPY

THIS CERTIFICATE IS A COPY OF THE ORIGINAL FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MD. IT IS NOT VALID UNLESS IT IS ACCOMPANIED BY THE ORIGINAL.

541

CERTIFICATE OF DEATH

Reg. Dist. No. 75

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Pennsylvania</u> b. COUNTY <u>York</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester</u>				c. LENGTH OF STAY IN 1b <u>7 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Longview Nursing Home</u>				e. STREET ADDRESS <u>209 Fredrick St.</u>			
3. NAME OF DECEASED (Type or print) <u>HANNAH Gulick Walker</u>				4. DATE OF DEATH <u>January 19 1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 11, 1868</u>	
9. AGE (In years last birthday) <u>89</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Isaac Gulick</u>				14. MOTHER'S MAIDEN NAME <u>Savilla Ulrick</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Miss Gertrude Walker</u>		Address <u>HANOVER PA.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Myocarditis</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arterio-sclerotic Cardiovascular Disease</u> DUE TO (c) <u>-</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>-</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>Sept 3</u> , 19 <u>51</u> , to <u>JAN 19</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>JAN 18</u> , 19 <u>58</u> , and that death occurred at <u>1:30 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Joseph E. Bush</u> M.D.				ADDRESS (Street, city or town, state) <u>Hampstead Md.</u> DATE SIGNED <u>1-19-58</u>			
PHYSICIAN'S NAME (Type) <u>Joseph E. Bush M.D.</u>				ADDRESS <u>Hampstead Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/1/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>River View</u>		22d. LOCATION (City, town, or county) (State) <u>Northumberland Pa</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frederick Bucher</u>				ADDRESS <u>Hanover Pa</u>		24a. REC'D BY REGISTRAR <u>Jan 21</u> DATE <u>Jan 21 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Mrs. W. S. Danner</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BUREAU 10

BUREAU V. 2

JAN 28 1953

RECEIVED

NAME OF DECEASED <i>John Doe</i>		DATE OF DEATH <i>Jan 25 1953</i>	
PLACE OF DEATH <i>Home</i>		CITY <i>Baltimore</i>	
COUNTY <i>Harford</i>		STATE <i>Md.</i>	
AGE <i>45</i>		SEX <i>Male</i>	
MARRIAGE <i>Married</i>		OCCUPATION <i>Teacher</i>	
CAUSE OF DEATH <i>Heart Disease</i>		MANNER OF DEATH <i>Natural</i>	
SIGNATURE OF PHYSICIAN <i>Dr. J. Smith</i>		SIGNATURE OF REGISTRAR <i>John Doe</i>	
DATE OF SIGNATURE <i>Jan 26 1953</i>		DATE OF SIGNATURE <i>Jan 26 1953</i>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

542

CERTIFICATE OF DEATH

00537

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore City 3 11	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 1yr, 5mths, 5days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3 Y 0 1 - 4	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS 911 McAleer Court, Balto 2	
3. NAME OF DECEASED (Type or print) First Harry Middle Wilbur Last Wallace		4. DATE OF DEATH Month Jan Day 20 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. B. DATE OF BIRTH 3-13-83
9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shipyard labor		10b. KIND OF BUSINESS OR INDUSTRY 217-09-2912	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Andrew Jackson Wallace		14. MOTHER'S MAIDEN NAME Harriett Gordon	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-09-2912	
17. INFORMANT Hospital records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease 4 20.0 DUE TO Generalized Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. Associated with Cerebral Arteriosclerosis with Psych. Reaction			
INTERVAL BETWEEN ONSET AND DEATH years years			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8-15 , 1956 , to 1-20 , 19 58 , that I last saw the deceased alive on 1-20 , 1958 , and that death occurred at 10 A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE Agustin del Campo M.D.		ADDRESS (Street, city or town, state) Springfield State Hospital. DATE SIGNED 1-20-58	
PHYSICIAN'S NAME (Type) Agustin del Campo M.D.		Sykesville, Maryland.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 1-23-58	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.	22d. LOCATION (City, town, or county) (State) BALTIMORE, MD.
23. FUNERAL DIRECTOR'S SIGNATURE McCully Funeral Homes		ADDRESS 130 E. Fort Ave	
24a. REC'D BY REGISTRAR JAN 23 '58		24b. REGISTRAR'S SIGNATURE Alfred Smith	

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH	
JAMES J. JONES		Male		35		1-1-1900	
PLACE OF BIRTH		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
New York City		Salesman		Myocardial Infarction		Natural	
DATE OF DEATH		PLACE OF DEATH		HOSPITAL		PHYSICIAN	
1-15-1935		New York City		St. Mary's Hospital		Dr. J. H. Smith	
TIME OF DEATH		TEMPERATURE		PULSE		RESPIRATION	
10:00 AM		98.6		72		18	
SIGNATURE OF PHYSICIAN		SIGNATURE OF WITNESSES		SIGNATURE OF DECEASED		SIGNATURE OF FUNERAL HOME	
[Signature]		[Signature]		[Signature]		[Signature]	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
1-15-1935		1-15-1935		1-15-1935		1-15-1935	

RECEIVED
JAN 23 1935
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00538

Reg. Dist. No.

543

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 2yrs. 2mos. 25days Hagerstown 2103-2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		d. STREET ADDRESS 337 W. Washington St.	
3. NAME OF DECEASED (Type or print) First James Middle William Last WRIGHT		4. DATE OF DEATH Month January Day 6, Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 4, 1887
9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months 6 Days 19 Hours 58 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown Joseph Wright		14. MOTHER'S MAIDEN NAME Mary Hoffmaster	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-09-2804	
17. INFORMANT Springfield Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal bronchopneumonia 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Infarctive myocardial fibrosis (c) Arteriosclerotic cardiovascular disease			INTERVAL BETWEEN ONSET AND DEATH 5 days. 1 yr. plus Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with circ. dist., with cerebral arteriosclerosis, with psychotic reaction. Fracture left hip.			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Unknown. 904.7	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 12/30/ 57 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hospital	20f. (City or town) (County) (State) Sykesville Carroll Md.
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James T. Marsh, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) James T. Marsh, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED 1/7/58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1-11-58	22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery	22d. LOCATION (City, town, or county) (State) Hagerstown Md.
23. FUNERAL DIRECTOR'S SIGNATURE R. M. Martin V. Pres.		24. REC'D BY REGISTRAR DATE JAN 14 '58	
ADDRESS 1601 Penna. Ave.		24b. REGISTRAR'S SIGNATURE W. H. Deuch	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JAN 15-1953

BUREAU V. S.

FOR STATE
HEALTH DEPT.

475

CERTIFICATE OF DEATH

00539

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>CARROLL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>133 PENNA. AVE</u>		d. STREET ADDRESS <u>133 PENNA. AVE.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARY MARGARET TEISER</u>		4. DATE OF DEATH Month Day Year <u>JAN. 4, 1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-1-1869</u>
9. AGE (In years last birthday) <u>88</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MD.</u>	
11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JACOB ESSICH</u>		14. MOTHER'S MAIDEN NAME <u>MARGARET BAUMGARDNER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>RHODA TROXELL WESTMINSTER, MD.</u>		Address <u>133 PENNA. AVE.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro Vascular Accident.</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cerebro Vascular Renal Disease.</u> DUE TO (c) <u>years.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 mos.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9/1, 1950</u> , to <u>1/4, 1958</u> , that I last saw the deceased alive on <u>1/3, 1958</u> , and that death occurred at <u>7:00 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>G. Allen Moulton</u>		ADDRESS (Street, city or town, state) <u>148 W. MAIN ST. WESTMINSTER, MD.</u>	
PHYSICIAN'S NAME (Type) <u>G. ALLEN MOULTON, M.D.</u>		DATE SIGNED <u>1/7/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1-7-1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>TRIDERS CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>WESTMINSTER, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>David G. Bankard</u>		ADDRESS <u>Westminster, Md.</u>	
24a. REC'D BY REGISTRAR <u>Jan 21 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Overman</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page could be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES H. HARRIS		65		M		W		JAN 15 1890		BALTIMORE		MD		USA			
MARRIAGE		DATE		PLACE		CITY		STATE		COUNTRY							
MARRIED		JAN 15 1910		BALTIMORE		MD		USA									
CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY							
HEART DISEASE		NATURAL		BALTIMORE		MD		USA									
DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY									
JAN 21 1958		BALTIMORE		MD		USA											
SIGNATURE OF PHYSICIAN		DATE		PLACE		CITY		STATE		COUNTRY							
JAMES H. HARRIS		JAN 21 1958		BALTIMORE		MD		USA									
SIGNATURE OF REGISTRAR		DATE		PLACE		CITY		STATE		COUNTRY							
JAMES H. HARRIS		JAN 21 1958		BALTIMORE		MD		USA									

BUREAU V. S.

JAN 21 1958

RECEIVED

544

CERTIFICATE OF DEATH

00541

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 8mos. 14days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Emma Middle YINGLING Last YINGLING		4. DATE OF DEATH Month January Day 10 Year 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 4, 1872
9. AGE (In years last birthday) yrs. 85		IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Josephus Moses Yingling		14. MOTHER'S MAIDEN NAME Amanda Corbin	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. -	
17. INFORMANT Springfield Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic Heart disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c) Years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with senile brain disease with psychotic reaction.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 26, 1957 , to January 10, 1958 , that I last saw the deceased alive on January 10, 1958 , and that death occurred at 2:40 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Agustin del Campo		ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 1/10/58	
PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.		Sykesville, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial Jan 13/58		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY Poplar		22d. LOCATION (City, town, or county) (State) Balto Co, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE A. Donovan		ADDRESS 3818 Roland Ave	
24a. REC'D BY REGISTRAR JAN 13 '58		24b. REGISTRAR'S SIGNATURE W. H. Beach	

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES H. HARRIS		2. SEX Male		3. AGE 65		4. DATE OF DEATH Jan 13 1938	
5. PLACE OF DEATH Home		6. CITY Baltimore		7. COUNTY Baltimore		8. STATE Maryland	
9. OCCUPATION Retired		10. CAUSE OF DEATH Heart Disease		11. DISEASE OR INJURY Coronary Artery Disease		12. PLACE OF BIRTH Baltimore	
13. DATE OF BIRTH Jan 13 1873		14. PLACE OF BIRTH Baltimore		15. COUNTY OF BIRTH Baltimore		16. STATE OF BIRTH Maryland	
17. NAME OF FATHER John H. Harris		18. NAME OF MOTHER Mary E. Harris		19. NAME OF SPOUSE Elizabeth Harris		20. NAME OF CHILDREN None	
21. NAME OF NEXT OF KIN None		22. NAME OF PHYSICIAN None		23. NAME OF BURIAL PLACE None		24. NAME OF CEMETERY None	
25. NAME OF MINISTER None		26. NAME OF CHURCH None		27. NAME OF FUNERAL HOME None		28. NAME OF FUNERAL HOME None	
29. NAME OF FUNERAL HOME None		30. NAME OF FUNERAL HOME None		31. NAME OF FUNERAL HOME None		32. NAME OF FUNERAL HOME None	
33. NAME OF FUNERAL HOME None		34. NAME OF FUNERAL HOME None		35. NAME OF FUNERAL HOME None		36. NAME OF FUNERAL HOME None	
37. NAME OF FUNERAL HOME None		38. NAME OF FUNERAL HOME None		39. NAME OF FUNERAL HOME None		40. NAME OF FUNERAL HOME None	
41. NAME OF FUNERAL HOME None		42. NAME OF FUNERAL HOME None		43. NAME OF FUNERAL HOME None		44. NAME OF FUNERAL HOME None	
45. NAME OF FUNERAL HOME None		46. NAME OF FUNERAL HOME None		47. NAME OF FUNERAL HOME None		48. NAME OF FUNERAL HOME None	
49. NAME OF FUNERAL HOME None		50. NAME OF FUNERAL HOME None		51. NAME OF FUNERAL HOME None		52. NAME OF FUNERAL HOME None	
53. NAME OF FUNERAL HOME None		54. NAME OF FUNERAL HOME None		55. NAME OF FUNERAL HOME None		56. NAME OF FUNERAL HOME None	
57. NAME OF FUNERAL HOME None		58. NAME OF FUNERAL HOME None		59. NAME OF FUNERAL HOME None		60. NAME OF FUNERAL HOME None	
61. NAME OF FUNERAL HOME None		62. NAME OF FUNERAL HOME None		63. NAME OF FUNERAL HOME None		64. NAME OF FUNERAL HOME None	
65. NAME OF FUNERAL HOME None		66. NAME OF FUNERAL HOME None		67. NAME OF FUNERAL HOME None		68. NAME OF FUNERAL HOME None	
69. NAME OF FUNERAL HOME None		70. NAME OF FUNERAL HOME None		71. NAME OF FUNERAL HOME None		72. NAME OF FUNERAL HOME None	
73. NAME OF FUNERAL HOME None		74. NAME OF FUNERAL HOME None		75. NAME OF FUNERAL HOME None		76. NAME OF FUNERAL HOME None	
77. NAME OF FUNERAL HOME None		78. NAME OF FUNERAL HOME None		79. NAME OF FUNERAL HOME None		80. NAME OF FUNERAL HOME None	
81. NAME OF FUNERAL HOME None		82. NAME OF FUNERAL HOME None		83. NAME OF FUNERAL HOME None		84. NAME OF FUNERAL HOME None	
85. NAME OF FUNERAL HOME None		86. NAME OF FUNERAL HOME None		87. NAME OF FUNERAL HOME None		88. NAME OF FUNERAL HOME None	
89. NAME OF FUNERAL HOME None		90. NAME OF FUNERAL HOME None		91. NAME OF FUNERAL HOME None		92. NAME OF FUNERAL HOME None	
93. NAME OF FUNERAL HOME None		94. NAME OF FUNERAL HOME None		95. NAME OF FUNERAL HOME None		96. NAME OF FUNERAL HOME None	
97. NAME OF FUNERAL HOME None		98. NAME OF FUNERAL HOME None		99. NAME OF FUNERAL HOME None		100. NAME OF FUNERAL HOME None	

BUREAU V. 8

JAN 13 1938

RECEIVED